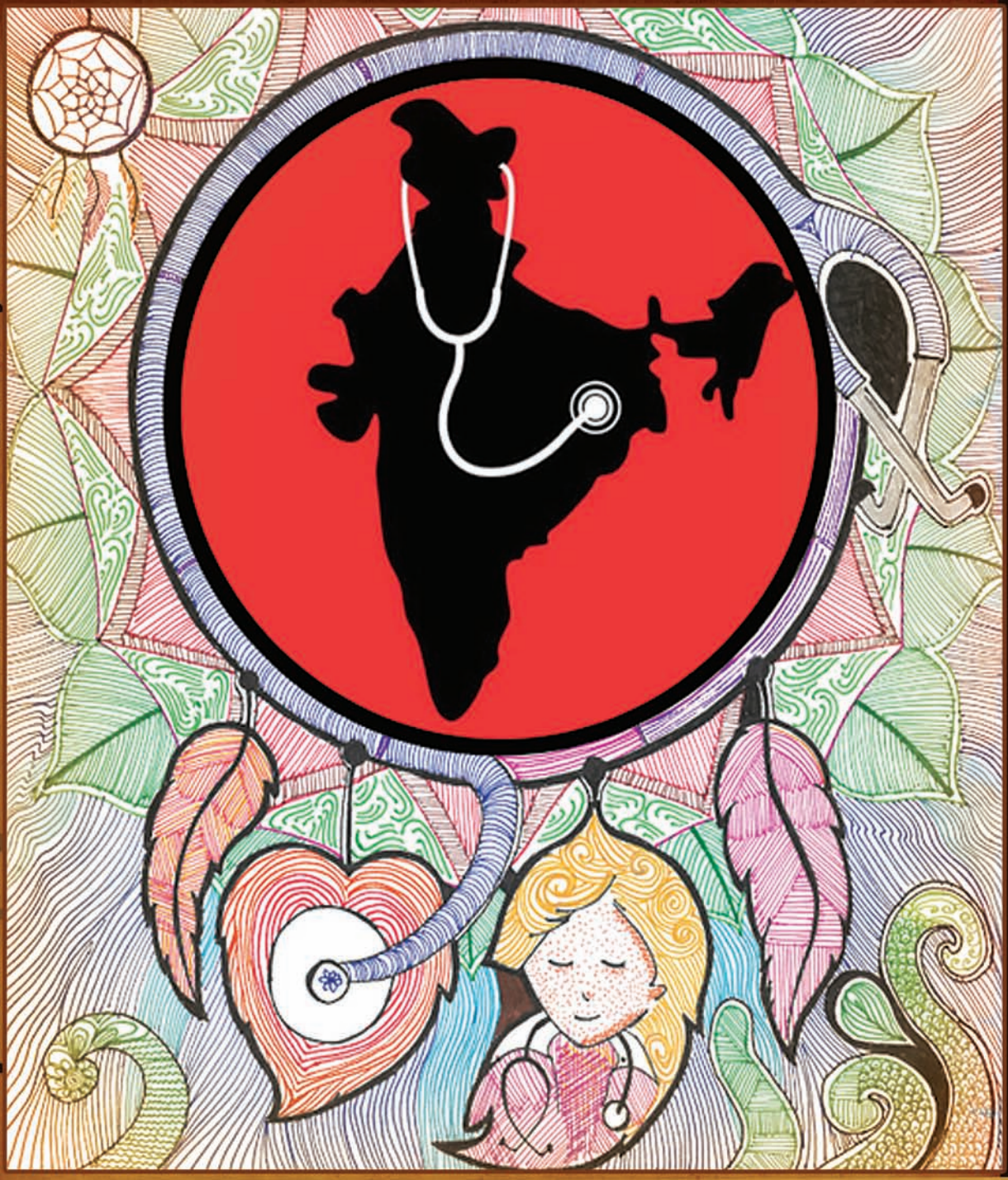
residream



Dermatology Residents Education And Motivation Bulletin

Volume - 6 | Issue - 1 | July / August - 2019 | Pages - 48

Editorial

"If you can DREAM it, you can DO it" – WALT DISNEY

When I sit back to write the editorial for Residream, the first thing that runs through my mind is this famous quote by Walt Disney. Back in 2015, during 1st year of my postgraduation I had dreamt of being a part of Residream. Today having got an opportunity to be the Editor-in-chief of this esteemed newsletter, there are so many, who have pushed me forward to achieve my dreams, to whom I would be ever grateful. I would say to the residents reading this magazine, yes! the baby steps start from residency itself.

Dermatology being on top today, dermatology residents are among the brainy, skillful and competent minds. Given a right platform, at the beginning of their career, they can showcase and accomplish in plenty. Residream is one such platform, where the residents can express themselves, without any restrictions, to the best of their ability. Residream, debuted in 2013, presently, stands strong, with its roots intact and branches spread out, under IADVL. It has successfully completed 5 volumes, and with this edition, it marks the dawn of 6th edition.

There are many respected teachers and residents who have been behind the success story of this newsletter. We at the editorial board, are immensely grateful to Dr P Narasimha Rao, Dr Umashankar Nagaraju and all present and past, respected executive committee members for encouraging us in every path, in all possible ways. It is an honor for me to take up this responsibility from the zealous, ever-helpful Dr. Isha Narang. It is a matter of absolute glee to have got this opportunity to guide an enthusiastic, hardworking editorial team, comprising of residents from all over India; Dr. Ashwini, Dr. Farhat, Dr. Kinnor, Dr. Monalisa and Dr. Ratnakar, blessed with extraordinary thoughts and have let leash a smorgasbord of inventiveness.

This edition has a special feature, of not only being for the residents but also by the residents in true terms. This edition starts with a quick review on the International Liaison Committee by the world-renowned dermatologist and our beloved teacher, Dr. Rashmi Sarkar along with the guiding force of Residream Dr. Saloni Katoch. A quick eye-catching Chit Chat, with the man who is the strongest pillar of IADVL,

Dr P Narasimha Rao. The golden caves of Dermatology in India; AIIMS, PGIMER, JIPMER and KMC – MANIPAL, has been elaborately explored by our residents in this edition. Want some quick review on difficult topics, refer to the Dermanotes. A set of grueling quiz to grind your grey matter is in this edition. Followed by interesting reports on various cases, which are limited and engrossing. Through my lens and Memer's corner, is something which is pristine and brand new. We end our edition by Derma – Glossary – which let us know in-depth meaning of words commonly used in dermatology. A special mention on the magnificent cover page with a lot of meaning by very talented Dr Kumari Monalisa.

We at the editorial, have put in lot of sweat, time and hard work for this master-piece. The popularity of Residream and Yuvaderma E-bulletin of various states, under National Resident Connect Committee, is shooting up with every new issue. The very talented, dedicated editorial board is already prepping up the next issue. Till then,

Hope you have a great read!
We are looking forward to your contributions for the next issue.
Thanks & Cheers!
Signing off...

DR. PREETHI B NAYAK
Editor-in-chief, Residream
Convener, National Resident Connect Committee, IADVL, 2019

INDEX

This year IADVL has the theme of year as 'Fight the steroid misuse' and we welcome the young members of this forum to take active part in this yearlong campaign of public awareness. And it heartening to note that IADVL RESIDENT connect is conducting an essay and poster competition throughout India on this theme of the year.

President's preamble

Dear Residents,

It is wonderful to share my thoughts with you on this young dermatologist's forum of IADVL the RESIDENT DREAM Bulletin. If my understanding is right, this must be its 6th year of publication of this bulletin. This IADVL Resident connect forum is doing excellent work in acting as a catalyst for stimulating residents to further their concepts in education through articles, case discussions, quizzes etc., while being at the same an interactive forum for sharing of knowledge.

I consider it my privilege to write the foreword to this year's bulletin. I am sure the articles and discussion this bulletin contains will be of great benefit to the residents. This year IADVL has the theme of year as 'Fight the steroid misuse' and we welcome the young members of this forum to take active part in this yearlong campaign of public awareness. And it heartening to note that IADVL RESIDENT connect is conducting an essay and poster competition throughout India on this theme of the year. And I am happy to announce that the best essay and poster selected by your forum among those received would be awarded prizes during our national conference 'DERMACON' Pune.

Lot of work goes into planning these activities and compiling a news bulletin and I congratulate the team members of this wonderful effort. You are the future of dermatology in India and I am very proud of your wonderful work.

I Wish the IADVL RESIDENT connect and RESIDENT DREAM all the best in its endeavors.

DR. P. NARASIMHA RAO

President, IADVL 2019

Resident DREAM (Dermatology Resident Education & Motivation) is the novel newsletter designed for and by our beloved residents. This newsletter is the best platform for the residents to share their views on post-graduation curriculum, clinical case discussion, exchange of ideas to prepare them for life after residency.

Honorary General Secretary speaks

Dear Residents,

Namasthe!

Resident DREAM (Dermatology Resident Education & Motivation) is the novel newsletter designed for and by our beloved residents. This newsletter is the best platform for the residents to share their views on post-graduation curriculum, clinical case discussion, exchange of ideas to prepare them for life after residency.

It is indeed my pleasure to have Dr Monalisa Gupta, Dr Ratnakar Shukla, Dr Kinnor Das, Dr Farhat Fatima and Dr Ashwini R Mahesh as members from north, west, east, north east and south respectively as its members and Dr Isha Narang as advisor of resident connect who have proved her efficiency as convener for the past fruitful year. Dr. Preethi B Nayak who is a promising IADVLite of future is leading the team as convener at present and as you all know she has done a marvelous job till now. This is the dynamic team picked based on their efficiency and are capable of delivering the best to our residents.

Last year we have initiated YUVADERMA, a state committee for and by the state residents to promote resident activities both at state and zonal level and to put this under one umbrella of RESIDENT CONNECT. The activities is in the form of resident updates for post-graduate examination, CME's, workshops, Quiz, etc. Moreover this helps to disseminate information of all IADVL programs designed for PLMs like national and international scholarships, research grants, thesis grants and awards. What's App group is created in each state to keep all residents in one loop. If you do not have access to YUVADERMA, you may please contact Dr. Preethi Nayak or myself so that we can assist you with best possibilities.

All of you, who are soon to complete 5 years of provisional membership and/or obtained a postgraduate (PG) degree/diploma in Dermatology and registered their PG qualification with the MCI/State Medical Council, are notified to become Life Members (LMs) at the earliest. It may be mentioned that Provisional Life Membership is granted for a period of 5

There are many benefits and privileges of being an IADVL LM. To mention few, only a LM can apply for orations, awards, grants, scholarships, observer ships and also can become members of international societies. Moreover, life membership of the association will enable you to cast your vote in the IADVL Elections and participate actively in the functioning of the association at both State and National levels.

years only within which a PLM has to convert to LM, failing which he/she ceases to be a member of the association.

There are many benefits and privileges of being an IADVL LM. To mention few, only a LM can apply for orations, awards, grants, scholarships, observer ships and also can become members of international societies. Moreover, life membership of the association will enable you to cast your vote in the IADVL Elections and participate actively in the functioning of the association at both State and National levels.

Conversion from PLM to LM is an easy process and can be done through the Online Membership Application System (OMAS) on the IADVL website (www.iadvl.org).Those PLMs, who have migrated to another state branch after post-graduation, can write to the Secretary of the parent State Branch (where their PLM is registered) for a No Objection Certificate (NOC) and, thereafter, apply for conversion from PLM to LM and State Branch transfer concurrently.

I also request all residents across the country to sign up at www.iadvl.org and gain access to a online membership privileges. IADVL DermApp is member friendly and gives you information at your fingertips on what is happening on IADVL particularly on many useful announcements for residents which are being done frequently. Do not miss to download the app and start utilizing the gifted opportunities.Lastly, I urge all residents to be active in this unique platform which takes you through memorable journey.

Best wishes

DR. UMASHANKAR NAGARAJU

Honorary Secretary IADVL 2019

Resident DREAM
"There is something mysteriously powerful when young inchoate minds come into contact with older and more worldly ones in a spirit of intellectual and creative endeavor - if I believed in progress, I suppose that's what I'd call it."
- Will Self

Message from Past Advisor

As I look back, I see five years of hard work, dedication, creativity, deadlines, team effort and learning. What began as a professional endeavor in the year 2013 gave me memories and friends for life. Through the various roles that I have been fortunate enough to essay, we have tried our best to benefit post graduate students both academically and professionally with this newsletter. My association with this bulletin, from being an associate editor to the Editor in chief and finally the advisor has been nothing short of phenomenal. To witness the growth of a novel vision into a nationwide phenomenon for the young and budding talent of our field has been exemplary. I would encourage post graduate students all across the country to be a part of both Yuvaderma and Resident DREAM, for by contributing, they will learn so much more about the lessons and values that these newsletters have to offer.

I would like to share a few learning experiences from my journey to give students an insight into the working of the Resident DREAM. So, what did I learn as a post graduate from this bulletin? I learnt how to find my work-life balance. As students we learnt to divide our time between the regular post graduate studying and the extra-curricular activities that we were participating in.

We learnt to prioritize and delivered to the best of our abilities without neglecting our health and studies. Be an optimist and see the opportunity when there is an announcement for submission of articles for such newsletters. Seize the opportunity, make that effort, face challenges, be intrigued by mistakes and keep on learning.

Teamwork is another pearl I imbibed, the team of the Resident connect committee is a diverse one and represents a mini India in itself. With residents from all corners of the country, we learnt to work in coordination with each other.

We learnt through each other's experience and became confident by sharing thoughts and ideas. We inspired, motivated and encouraged each other to work to one's full potential. We also disagreed on things, respected each other's opinion and adjusted with one another for the

Knowledge, information, learning and life experiences have all been passed down from our teachers to the budding minds through this channel known as the 'Resident DREAM.' We absorbed like sponges the inspiring and motivating journeys of our teachers and professors. We learnt that success doesn't come easy, it's a product of hard work, resilience and dedication.

betterment of the newsletter. So, volunteer when you have the chance to and be a part of this wonderful learning and growing process.

My journey taught me that failure is a part of success. We learnt that giving up is never an option for people who want to make a difference and that knowledge and opportunities grow infinitely when shared. I hope these snippets from my experience encourage young residents to break those shells and develop their academics and extra-curricular hobbies alike.

Knowledge, information, learning and life experiences have all been passed down from our teachers to the budding minds through this channel known as the 'Resident DREAM.' We absorbed like sponges the inspiring and motivating journeys of our teachers and professors. We learnt that success doesn't come easy, it's a product of hard work, resilience and dedication. We evolved from students to practitioners with these principles firmly seeded in our minds. So, my dear residents, not only did we learn from our teachers, we became them, to pass on the light to the generation next. As the Baton passes on to a very bright and creative Editor in chief, Dr. Preethi B Nayak, I wish her and the entire team of the Resident connect committee the very best for their tenure ahead. My heartfelt gratitude to the IADVL national and state executive committees for supporting and encouraging these resident oriented activities. I hope that more and more residents contribute to this endeavor and become aware of this opportunity for both personal and professional development.

Best wishes,

DR. SALONI KATOCH

Past Advisor, National Resident Connect Committee, IADVL

The involvement of residents from across the country is the barometer of the reach and success of the resident connect committee. The residents are equipped with such a resource to say and express their notions. It is also an excellent opportunity to connect with the working of IADVL. We have evolved in a way that now the editorial team is representative of all the zones of the country.

Message from Advisor

"Those who do not move, do not notice their chains"
- Rosa Luxembourg

It is important to adapt, it is important to change and it is essential to move forward. So moving on, and evolving into yet another new edition of RESIDREAM. As during evolution, man still carries a stamp of it's origin; no matter where we go forward with dermatology, we will always be rooted to our origins including our alma mater and IADVL. Both of these gives us opportunities to thrive and bloom.

The involvement of residents from across the country is the barometer of the reach and success of the resident connect committee. The residents are equipped with such a resource to say and express their notions. It is also an excellent opportunity to connect with the working of IADVL. We have evolved in a way that now the editorial team is representative of all the zones of the country. These representatives will also closely liaise with the state 'Yuvaderma' teams. Yuvaderma itself marks the evolution of resident connect committee.

I'm glad that a very talented Dr Preethi Nayak is taking over as the new Convener and editor. I wish her and the team very best. I also urge all the dermatology residents to utilize this platform to the fullest. The magazine is also evolving and reflecting the new outlook of dermatology residents. Your feedback and ideas are essentially what makes it reflective.

Looking forward to an exciting new edition!

DR. ISHA NARANG

Advisor, National Resident Connect Committee,

IADVL 2019

INTERNATIONAL LIAISON COMMITTEE

A Symbol of Solidarity & Vision

The IADVL International Liaison cell was initiated with a mission to liaise Indian dermatology with the rest of the world. With an intent of bridging gaps and strengthening professional bonds, it is heartening to see the progress that we as Indian dermatologists have now made at the global platform by participating as members and faculty in various international conferences and academic programs. IADVL is now carrying out various activities like workshops internationally. Many of our members have now been elected to various positions in different international societies. Sister society sessions are being organized at various international conferences like WCD, AAD, EADV and DASIL.

Scholarships and travel grants are now being offered on a mutual and reciprocating basis to help dermatologists acquire and specialize their skills. The article sheds light on few of the many international societies that are there today.

Women's Dermatology Society (WDS)

Wilma Fowler Bergfeld, MD, FACP, founded the Women's Dermatologic Society in 1973 and served as the first president to the organization. The Women's Dermatologic Society was formed to address the lack of women's participation as lecturers at the American Academy of Dermatology meeting. The group started with a handful of women and Dr. Walter Shelley about 40 years ago. The reason for its existence was to encourage women with advice from colleagues on how to lecture, time manage, be better dermatologists, write grants, reach major elected offices in the AAD and explore the many talents we have as women. Many male dermatology colleagues realized the value of this endeavor and joined WDS which presently has over 1,400 members in 33countries.

The Indian Wing of WDS was initiated by Dr. Rashmi Sarkar and is a special category for membership in the WDS. The membership for post graduate residents and fellows is complimentary and at no fees to the student. Apart from mentorship programs, social activities, an International journal, newsletters and networking receptions, the society also awards scholarships and travel grants to dermatologists. For further details one can log on to www.womensderm.org.

The Dermatologic & Aesthetic Surgery International League (DASIL)

The Mission of the Dermatologic & Aesthetic Surgery International League (DASIL) is to create a global community for the open exchange of knowledge and innovation by physicians specializing in Dermatologic and Aesthetic Surgery. As a benefit of membership, all members receive a complimentary subscription to the Dermatologic surgery journal, twice a year newsletter, access to scholarships and preferential registration fees for the workshops and congresses. Additionally, members can apply to the DASIL/ASDS International Traveling Mentorship Program (ITMP). This unique program provides training opportunities in collaboration with American Society for Dermatologic Surgery (ASDS). Dr. Venkataram

Mysore is the current president of DASIL and the organization is a member of the International League of Dermatological Societies (ILDS). For further information log on to https://thedasil.org/

Asian Society for Pigment Cell Research (ASPCR)

The ASPCR is one of the key dermatological organizations dedicated to pigment cell research and practice. The organization was founded in 2004 with the aim of promoting research, education and relations between those in the Asia-Pacific region who are interested in dermatological problems that arise from pigment cell abnormalities. The need to have an organized platform to present and discuss Asian pigmentary problems and to promote pigment cell research in this continent were the key drivers for the formation of ASPCR. The ASPCR secretariat was established in Chandigarh, India and its first conference was held in New Delhi in February 2005. This organization is a part of the International Federation for Pigment Cell Societies and membership benefits include access to the pigment cell and melanoma research (PCMR) journal, travel awards, scholarships, opportunities to present research, and social activity that promotes working relationships and friendships. For further information, log on to www.aspcr.org

WDS PHYSICIANS LEADERS MENTORS
Women's Dermatologic Society

International League of Dermatological Societies (ILDS)

The International League of Dermatological Societies is a non-governmental organization that works closely with the World Health Organization to improve skin health for people around the world. Its forerunner began in 1889 as the first of many World Congresses of Dermatology. Today, the ILDS represents dermatology at the highest level with over 170 Member Societies from more than 80 countries, with over 200,000 dermatologists. The ILDS has shaped international dermatology; from the World Congress of Dermatology, to providing grants for small scale initiatives in under-served parts of the world. The World Congress of Dermatology (WCD) takes place every 4 years. WCD has provided an opportunity for dermatologists to come together to share their clinical experiences and scientific advances on both a professional and personal level. For more details lo onto https://ilds.org

The IADVL International times, official newsletter of the IADVL international Liaison cell, throws light on the various international activities of the Indian association of Dermatologists, Venereologists and Leprologists and is available on www.iadvl.org under the newsletter section. In an effort to bring Indian dermatology to the world, the liaison cell has been carrying out various initiatives.

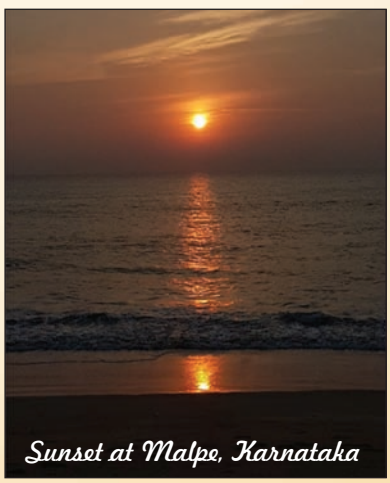
With the second largest pool of dermatologists after AAD, we hope to make our presence felt at the global level. We will make our mark at an international level with the continued efforts and academic excellence of our members.

Source of information : www.womensderm.org https://thedasil.org/, https://ilds.org, www.aspcr.org

Compiled by,
DR. RASHMI SARKAR
Chairperson, IADVL
International Liaison cell

DR. SALONI KATOCH
Member, IADVL
International Liaison cell

THROUGH MY LENS...



DR. KINNOR DAS
PG - 3
Silchar Medical College
& Hospital Sichar, Assam

DR. SANDHIYA RAMESH
PG - 3
KMC Manipal, MAHE, Karnataka

Chit Chat

FROM THE PRESIDENT'S DESK

Dr. P. Narasimha Rao

He is the National President, IADVL, 2019 & Editorial board member IJDVL from 2012. He was faculty of Department of Dermatology at Osmania & Bhaskar Medical College, Hyderabad, Telangana.

Let me first thank you for giving me this opportunity to respond to your interview. I tried to respond to your queries sincerely and in detail where possible. My best wishes to the IADVL resident forum who are doing wonderful work.

RS : How is your experience sir, sitting on the chair of national president and leading such a massive league of dermatologist?

Dr Rao : It is huge honor and a responsibility at the same time. Sometimes, it seems surreal, as this position was occupied by the stalwarts and doyens of Indian Dermatology. Fortunately, we have a large group of enthusiastic members who are dedicated to IADVL and consider it as a 'family' to help and work along with me. I feel privileged to lead this organization.

RS : Who has been your guiding force and motivation?

Dr Rao : It is difficult to point one person or event as a motivating factor. There are good number of them. My teacher and philosopher, Prof TSS Lakshmi encouraged me to take up IADVL activities very early in my career, and was instrumental of me becoming Hon Secretary of IADVL, Andhra Pradesh state branch way back in 1993-94 itself. I have seen my dear friend Dr Sacchidanand doing wonderful work for IADVL at national level very early in his career and he is an inspiration.

RS : Sir, what are the initiatives taken place during your term for the betterment of IADVL?

Dr Rao : IADVL is great institution which made its mark in academic and organizational front nationally and internationally. However, I noted that member welfare initiatives as a society for pan Indian dermatologists are very few. Hence this year EC has introduced and funded the "group accident insurance scheme' for the benefit of all its life members. This is the first such 'member welfare activity' fully supported by IADVL. It was launched from 1st April 2019. We are also looking at other initiatives for benefit of members.

RS : Are there any insurance schemes for PLM candidates?

Dr Rao : Right now, they are not extended to PLMs. Nonetheless, we are looking at the possibility of extending this accident insurance scheme to PLMs as well. The main requirement is having correct and

updated database of PLM members. I will surely explore this possibility further during my tenure.

RS : How to deal with pressure of publication as acceptance rate is very low in a good journal?

Dr Rao : This is an important question. First and foremost, don't consider issues such as its acceptance rate etc. at all, while choosing a write an article. Only look the journal at its relevance to your work! Do and perform well the acts which are in your control while preparing and sending the manuscipt.

Before this act, the primary requisite is to plan and write a good quality article to one's own satisfaction. For that, the data done need to be of a good quality and work done with sincerety. And in addition, author need to be patient and should not get perturbed by the questions raised by the reviewers, which often happens with good reviewers. Also, please note the timeline from submission of article to final appearance in print may take one to one-and-half years in any journal of repute. There are no shortcuts to success and only perseverance prevails.

RS : What are the basic constructs of writing a good research paper?

Dr Rao : First and foremost, selection of a good topic of relevance for research is the prerequisite! And then, having a good study design in place and doing good quality focused work. As less cut-and-paste, so much better. Only then, one can hope to have a good quality paper. Good research only happen when time and effort is devoted it. No other way!!

RS : What is the scope and future regarding DM/ DNB super speciality in dermatology field? Is there any need of separate superspeciality courses like cosmetic dermatology, paediatric dermatology, dermatosurgery, dermatopathology, leprosy, STD etc.?

Dr Rao : There is a good scope for post PG sub specialty in dermatology. In fact, National board (DNB) has cleared post DNB dermatology sub-specialty courses of one year each in Pediatric Dermatology and Dermatopathology last year. And they are considering similar course in Dermato surgery as well. The work on identifying the centers for these courses in going on. At present, we already have university affiliated 1-2 year post-PG courses in dermato-surgery, pediatric dermatology and procedural / laser dermatology under RGUHS-Karnataka, and MGR university,- Tamilnadu and in JIPMER- Pondicherry.

RS : Job opportunities are very much limited in government sector for a fresh passed out candidate, your take on this?

Dr Rao : On contrary, I opine that the opportunities for qualified dermatologist has increased enormously at present. Jobs with govt sector are always difficult as they are few and it has been the case from last 3 or 4 decades. However, now there are number of private medical colleges and institutions to join as faculty. And many state governments are also trying to recruit more dermatologists in peripheral and district level hospitals.

RS : Can you please list few financial support and scholarship IADVL offers to it's resident?Sir, tell me in detail about thesis grant, awards for thesis, PG education task force.

Dr Rao : There are number of them. Plenty in fact. Please visit our website www.iadvl.org for all the information. Look at the IADVL academy sub-head and also at the scrolls. Keep looking for announcements periodically on this forum.

RS : How do we deal with Google gyan (knowledge)? People are getting equipped with wrong knowledge from Google.

Dr Rao : Only advise of mine is… to be patient with them. And counsel them wisely. We can not control these social media and other platforms as information outlets, some spurious. Need to learn to ride the tide.

The mantra for developing good clinical acumen is only by being sincere and by giving 'attention to detail'. Be ready to observe and learn, even the smallest detail. To develop skill IADVL offers number of CMEs, workshop and targeted training programs. Enthusiasm and aptitude to patient care are the traits of successful and good clinicians. Patience is the key.

RS : People are offering skin consultations over Instagram, whatsapp and all over the internet. How do we stop the menace? What's your take on advertising?

Dr Rao : As per Supreme court directive, such practice is not to be indulged in and are considered wrong medical practice. And advertising is illegal as per our law for doctors. Unfortunately, these laws are seldom implemented in practice. But note the problem is too huge to be tackled by our association alone.

RS : How can we increase our clinical acumen and skills and what are common mistakes mostly done by residents?

Dr Rao : The mantra for developing good clinical acumen is only by being sincere and by giving 'attention to detail'. Be ready to observe and learn, even the smallest detail. To develop skill IADVL offers number of CMEs, workshop and targeted training programs. Enthusiasm and aptitude to patient care are the traits of successful and good clinicians. Patience is the key.

RS : According to you, what is the biggest challenge today for residents? Is there anything particular, where India is lacking as compared to other countries? How can we rectify that?

Dr Rao : While today's residents of India are bright and very intelligent, they are very ambitious too. Probably due to this reason, I have noted that 'stress' is higher in this generation and also the 'restlessness'. The challenges they need to address is impatience and anxiety for a quick outcome. Quality in any task only happens when sufficient time and effort is given to it. I feel our residents are no less than counterparts of other countries.

RS : After passing MD final exams people get busy with private practice, priorities change, so how to keep balance between academics and practice?

Dr Rao : One need to choose their options first. If interested in academics, join a medical institution. If want to involve in private practice fully, go ahead after acquiring the required skills. At present there are number of opportunities for private practitioners to keep abreast of advances in dermatology through CMEs and workshops.

RS : How can we reach non dermatologists to spread awareness of steroid abuse? As residents, can we do anything about it?

Dr Rao : Yes, young generation are the key to control this menace. First practice what you preach

in our hospital/ college. Start a social network group for this specific purpose. Social media is a very strong medium to spread this message. Also involve with IADVL group activities to know more about the initiatives taken up on this theme of the year 'stop topical steroid misuse". At your resident forum, start few new initiatives on this issue. You are welcome to contact IADVL community dermatology and ITATSA group members for more information and participation in our activities.

RS : What is the importance of Hansen's disease in a dermatologist's practice after post-graduation?

Dr Rao : Leprosy is an important part of our curriculum and specialty, so much so that it is included in the title of our association as well! It is very important for dermatologist to know fully about the management of all aspects of this dreaded disease, as A) Dermatologists are the only qualified specialists to manage and treat leprosy patients and their complications. B). Our country India is the hub of leprosy, holding about 60% of leprosy patients of the world, and if we do not manage, no one else can! It is our obligation to our community. And a duty.

RS : How important is it to be updated? Any source for ready reckoners? Which all books do you refer to on a daily basis?

Dr Rao : Everyone has his/ her own methods. And choice of books. With information explosion, right now there are number of sources at internet. When I was young to dermatology I especially used to like the book 'manual of dermatological therapeutics', as useful for day to day reference, between patients. And also the book 'Evidence-based dermatology'. Our IJDVL and IDOJ journals, if read regularly are fantastic source as well. Basically, it is an individual choice.

RS : What motivates you and helps you maintain high spirits at all times?

Dr Rao : By keeping good company of friends. It is very important to involve in sports as well. I play tennis 5 days-a-week. And by looking at positives in every situation and in each individual, one can strive to develop good spirited nature and benevolent demeanor.

RS : Sir, Pearls of wisdom to residents:

Dr Rao : You are brighter and more intelligent than your previous generations. And more endowed too. However, one need to set their priorities right. And continue to work in that direction. Sky is the limit for your achievements. Never compromise for less-than-best effort from you, when patient care is concerned. Avoid contempt for old and fascination for new. Always patient and their interest should come first. Strive to relieve patients who come to you of their distress. If one focuses to become a 'very good dermatologist' rest of things, such as fame, wealth and recognition, fall in place with time for sure.

Thank you so much sir for those encouraging words, and providing an insight into the quality of work done by our association - IADVL

DR. RATNAKAR SHUKLA
PG-3,
Dr. D.Y. Patil Medical College,
Nerul, Navi Mumbai, Maharastra

Derma notes-1

"Lotion Always The Best Potion : Bringing About The Right Choice

Moisturizers are **bland oleaginous** formulations which help in maintaining **10-30% water content** of skin

No consensus regarding the definition of moisturizer.

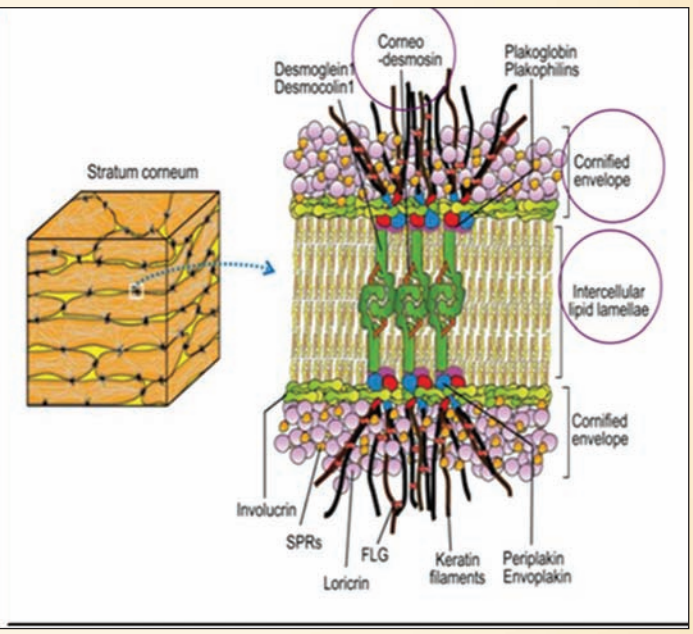
Term given by **Marketers**, promoting its function to moisten the skin.

Stratum corenum components

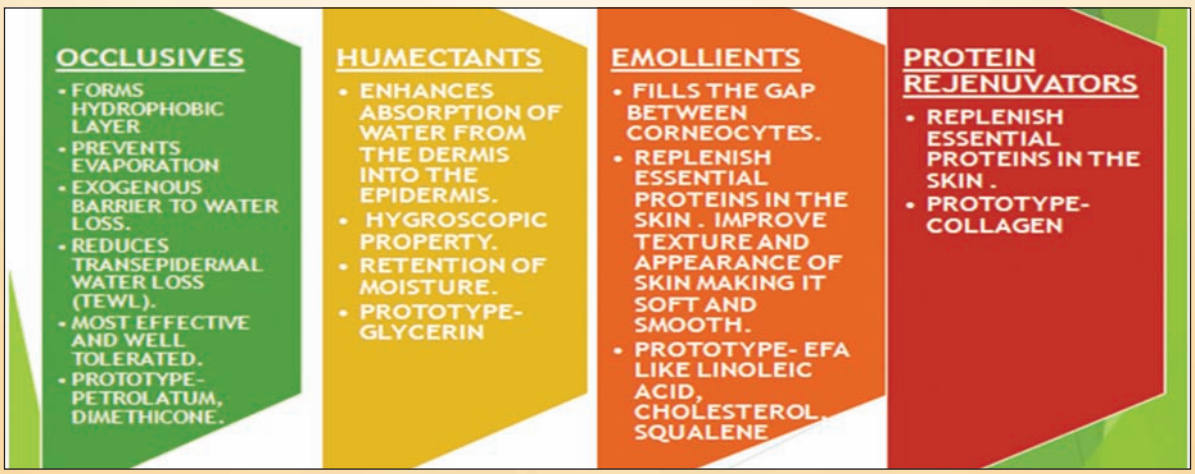
Among the intercellular lipids, ceramides (50%), cholesterol (25%) and free fatty acids (15%) are present in the ratio of 3:1:1.

THREE KEY COMPONENTS:

- **INTERCELLULAR LIPIDS** - Produced in the SG and stored in lamellar/odland bodies, which deliver these to SC.
- **CORNIFIED ENVELOPE** - Consists of highly crosslinked insoluble proteins and the extracellular lipids anchoring on it. Provides mechanical resistance. Composed of proteins such as keratin, involucrin, loricrin, corneodesmin and fillagrin.
- **CORNEODESMOSOMES** - apparatus is responsible for cell adhesion of corneocytes.



Moisturizers are classified as Emollients, Humectants, Occlusives and Protein Rejenuvators.



Ceramide preperations

- They are not regarded as a class of moisturizer.
- Increasingly used in cosmeceuticals and in treatment of atopic dermatitis.
- Role in structuring and maintaining the water permeability barrier function.
- Their oil solubility function helps in their easy incorporation into moisturizers.
- Very expensive

Natural moisturizing factor

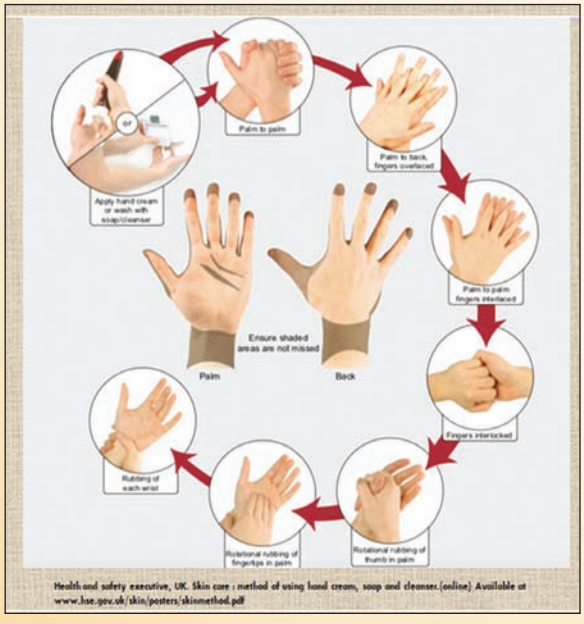
- Present in the Corneocytes and is a mix of hygroscopic molecules – Natural Humectant.
- Occupies 10% Corneocyte Mass and 30% Dry Weight of stratum corneum (SC).
- 50 % are amino acids originating from proteolysis of keratinocyte protein filaggrin.
- Rest include salts like Lactates, Urea, And Electrolytes.

Prescription emollient devices

New concept - Balanced proportions of SC specific lipids - NMF, Ceramides and pseudoceramides		
Have distinct ratios of lipids that mimic endogenous composition.	510 (K) cleared devices - clearrance is based upon capability to decrease tewl	Four products - epicream (Dr. Reddy Labs), Atopiclair (MINARINI), MIMYX/ Physiogel (Steifellabs), Eletone Emulsion (Mission Pharma)

These contain 3:1:1 ratio of ceramides, cholesterol and free fatty acids , thus thought to repair the skin barrier. However they are very expensive.

How to apply hand cream



Moisturizers for xerosis

- Moisturizers containing ceramides, cholesterol, fatty acids, lipid precursors, glyceryl glucoside, alpha hydroxy radicals, humectants–Improve barrier function.
- Alpha or beta hydroxy acids– Promote corneocyte desquamation ,useful in photoaged skin, exfoliative property.
- Urea has been shown to reduce TEWL in atopic and ichthyotic patients.

Moisturizers for atopic dermatitis

- Current emollient of choice-Petrolatum base demollients.
- Physiological ceramide mixtures: -> excellent barrier repair.
- Moisturizers are a primary therapy for mild AD. Recommend application soon after bathing.
- Adjunctive therapy for moderate-to-severe AD.
- No specific recommendations regarding vehicle systems and types of moisturizers (eg, petrolatum vs more expensive “barrier creams”).
- Prescription emollient devices - AAD guidelines do not recommend their use because they have not shown superiority over other moisturizing products.
- NO SINGLE MOISTURIZER HAS BEEN PROVED TO BE SUPERIOR, AND THIS CHOICE CAN BE MADE BASED ON PATIENT AND PROVIDER PREFERENCE.

Moisturizers for Eczema

- Cornerstone therapy for asteatotic eczema. Useful in hand eczema .
- Apply emollients liberally after work. apply after every hand wash.
- Avoid urea based moisturizers - increase skin permeability to irritants.
- EMOLLIENT OF CHOICE - PETROLATUM BASED PRODUCTS
- Combining occlusives and humectants enhances water holding capacity of skin eg glycerin with occlusive.
- Ointment are preferred over creams as creams may contain potentially sensitizing preservatives and mildly irritating emulsifiers.

Moisturizers fro Acne

- Dimethicone and cyclomethicone are silicone derivatives and used in oil-free facial moisturizers.
- IDEAL MOISTURIZER – non comedogenic, no irritation potential, diminish skin oiliness, decrease tewl, increase skin hydration, cosmetically acceptable.
- Glycerin is the Most Effective Humectant.
- Glycerin (humectant) and dimethicone (occlusive agent) are usually combined.
- Hyarulonic acid and sodium Pyrrolidone Carboxylic Acid (PCA), which are Humectants, may be used in addition to glycerin to decrease stickiness (caused by glycerin).
- Due to drawback for acneprone skin; petrolatum, mineral oil and lanolin are less commonly used.
- Lanolin not preferred due to-Odor, expense, allergic contact dermatitis.
- Mineral oil is lightweight and inexpensive oil. however it is comedogenic.

Moisturizers for rosacea / Sensitive skin

- Hydrophilic formulations with no or minimal lipid percentage like hydrogels, hydro dispersion gels, o/w creams, lamellar creams are preferred.

What is not preferred?

- Petrolatum- Most effective occlusive, diffuses into the intercellular lipid bilayer of skin, however not preferred.
- AHA, Urea, Alcohol, Acetone, Menthol- Irritants thus not prefered.
- Lanolin- allergic and irritant reactions.
- Fragrances- Avoid in sensitive skin.
- Astringents, Toners, Abrasives, Sensory stimulants like Camphor, Menthol- Should be avoided.

Moisturizers for Psoriasis

- Emollient enhance penetration of topical corticosteroids through skin.
- Oil in water emulsions enhance penetration of UVA or UVB when used before irradiation and increase efficacy of phototherapy.
- Soft white petrolatum is a good moisturizer in psoriasis and can be used after topical coal tar and can be used in conjunction with dithranol or TCS , has a good steroid sparing effect

Urea containing preparation –

1. Reduces epidermal hyperproliferation.
2. Induces cell differentiation.
3. Causes reduction of DNA synthesis in the cells of basal layers.
4. Denatures keratin and interferes with quaternary structure.

Acknowledgement

I would like to thank Dr. Pooja Arora Mrig, Associate Professor in Dermatology at Dr. RML Hospital for her invaluable guidance in helping me understand this extremely diifficult topic of Moisturizers .

I would like to suggest the readers; a very good, handy and comprehensive book on Moisturizers, written by Dr. Rashmi Sarkar, published by Jaypee Brothers; for further reading.

DR. SOUMYA SACHDEVA
PG-2,
Ram Manohar Lohiya Hospital &
PGIMER, New Delhi

WITH THE GOLDEN CAVES OF DERMATOLOGY

Dr.Vinod Kumar Sharma

Professor & Head,
Department of Dermatology,
All India Institute of Medical Science, New Delhi.

He is professor & head, Department of Dermatology at All India Institute of Medical Science, New Delhi. He was also the Vice president of International Society of Dermatology 2013-2017 & Member in the Editorial Board of Dermatitis- Official Journal of American Society Of Contact Dermatitis. He has multiple national & international publications. Apart from that, he is really an amiable & inspiring personality & embodies himself as an inordinate tycoon in the world of dermatology.

KM : Sir, please share some of your experience in residency and based on the current scenario of Dermatology, how has it changed from your time?

Dr Sharma : I was excited to get residency in AIIMS. I moved from Ludhiana, a smaller town to Delhi. It was my first experience of living in a metro city. My teachers were leaders in their field – iconic figures. The environment was competitive, and it kept you on your toes. We learned a tremendous amount and gained confidence and interpersonal skills. Times have changed and residency in dermatology has been transformed from a lesser known specialty to a highly sought after one. The relationship between teachers and the residents have evolved. Super-specializations in dermatology, for example, dermatopathology, dermatosurgery, lasers and aesthetics have emerged. In our time, the focus was on clinical dermatology and histopathology and Leprosy and STDs were at the forefront.

KM : How it feels, being the head of India's one of the most pioneer institute? How was your journey through these years?

Dr Sharma : It was a great honor for me to get opportunity to chair a department (from May 2001), where my revered teachers like Late Professor LK Bhutani, Professor JS Pasricha and Professor RK Pandhi have been Heads of Department. I felt a great sense of responsibility to be this leader in academic dermatology and decided to devote full time and energy for the same. I planned to expand the department as per needs of new millenium. The department acquired state-of-the-art equipment like Lasers, PUVA therapy and NBUVB equipment. Many specialized procedures like vitiligo tissue grafting, fat transfer, flap excisions of BCC etc. were introduced into the department. Other than that, we improved our teaching programme by introducing slide seminars, case conferences, dermatopathology review and annual review of seminar list to introduce new topics. I'm most proud of the independent molecular research lab in dermatology that was established under my direction. It strengthened the basic research in the department especially in the

field of immunology and genetics of vitiligo and psoriasis with the help of PhD scholars.

My journey has been very pleasant and rewarding but with many life lessons as I had become HOD at the young age of 45 years. I continued to learn and started doing lasers, and introduced dermoscopy and PRP in the department. I carried out many ICMR, DBT research projects and edited several books including Textbook of Sexually Transmitted Diseases and AIDS. I contributed to increased visibility of Indian dermatology at the international level by research collaborations with University of Michigan, USA and by being part of the International Society of Dermatology and the American Academy of Dermatology, and by organising XI International Congress of Dermatology in 2013.

KM : Sir what are the courses and fellowships offered at the dermatology department of your institute?

Dr Sharma : The department offers courses in MD dermatology and venereology since 1950s and PhD in basic research in relation to dermatology.

Short - term training (1 to 3 months) in dermatosurgery, lasers, dermatopathology, pulse therapy and biologics in dermatology and pediatric dermatology is available to Indian and International applicants.

The department has an ongoing proposal for 1year post MD fellowship in dermatosurgery and lasers, clinical immunodermatology and pediatric dermatology. These fellowships are likely to start from January 2020 or soon after. These fellowships will have the salary of a senior resident and will be based on entrance examination like that for senior residents. So, lookout for them !

KM : Sir, do you think it matters which institute one graduates from in the long run?

Dr Sharma : It matters more initially but 2-3 years after graduation, less so. Making a successful career in dermatology is gradual process and training in a good institute gives you a good foundation. Ultimately, it depends on the ability of residents to capitalize on it. One may need to train further depending on their interests and goals.

KM : Sir what are the requirements for recent graduates who would want to join your esteemed institute as faculty members?

Dr Sharma : Faculty position at AIIMS, New Delhi requires an MCI recognized MD Dermatology and Venereology or MD Dermatology or equivalent degrees with three years' experience as a senior resident. The most important is interest in academics and research demonstrated by publications, knowledge of research methodology, community dermatology and national leprosy, STD and AIDS control programs. Good interpersonal skills are another essential requirement.

KM : What would be your advice to the residents in their three years of residency? How to excel in academics?

Dr Sharma : My advice all who join residency is to realize the potential of all the aspects of dermatology and not to focus too much on dermatosurgery or aesthetics from the beginning. Read consistently from the start. Participate enthusiastically in all clinical and academic activities. Keep your senior resident well informed. Maintain open channels of communication with fellow resident and the faculty including HOD. Finally coordinate with your co- trainees, they help you learn a lot. As a second-year resident, start teaching new trainees. It will help to consolidate your knowledge and build teaching skills.

KM : Being an author of multiple research papers, what would be your advice to the beginners on how to build up interest in research work and write a "clinical paper"?

Dr Sharma : My suggestion is to write a robust case reports as a resident. Be thorough with the thesis so that it may be published and may get you a travel grant for a conference. Express a keen interest in research and academics and ask the faculty will give you work related to clinical research. Do a scoping review of literature to identify research gaps, find new aspect of a disease to study. Avoid repetition of topic

areas as it reduces the impact and validity of your research efforts.

KM : What is better for dermatology residents, private practice or government jobs? Do you any time feel dermatology has reached a point of saturation?

Dr Sharma : Every new resident is at a cross roads after completing his/her degree. It is expected that most residents will go to private practice as government jobs are limited in number. However, a short 1-2year senior residency is a good preparation for private practice. You can join a well-established dermatologist or clinic to learn soft skills of patient management and client handling.

There is some degree of saturation in urban areas, but one can still find pockets where a new dermatologist can fit in. Suburban areas of a city are always in need of a specialist.

KM : How can a resident acquire more from a conference?

Dr Sharma : You must always choose a conference carefully, look at the presenting faculty and topics of discussion. Choose topics of interest, attend workshops, download slides if available or take notes for future reference. Talk to the speaker if possible. Attend plenaries of conference to listen to renowned speakers.

KM : Sir you might have presented so many presentations. How to become a good presenter?

Dr Sharma : Read widely on your topic. Review literature and add your personal experience on the subject. A good introduction, interesting slides, a few quotes or anecdotes can help to keep it engaging and lively. Have confident body language and practice a few times if you are anxious about public speaking.

KM : How important is it to be updated? Any source for ready reckoners? Which all books do you refer to on a daily basis?

Dr Sharma : Being updated is key in any field of medicine and dermatology is no different in that respect. Standard textbooks of dermatology are always useful to keep at hand. E-books of various authors make information easily accessible and are useful for rare diseases.

RAPID FIRE

- **Books or e-books**
  Books but e-books for ready reference in a clinical setting
- **Cosmetology or clinical dermatology**
  Clinical dermatology taking care of cosmetic concerns
- **Histopathology or Dermoscopy**
  I prefer dermoscopy but supplemented with histopathology as and when needed
- **Rooks/Bolognia/Fitzpatrick/Levers/IADVL (Order)**
  Fitzpatrick/Rooks/Levers
- **Favorite Movie**
  Silsila
- **Hobby**
  Travelling, reading etc
- **Your mentor**
  All my teachers. Professor NK Ganguly for research.
- **To marry or not to marry during residency?**
  It's a personal choice.
- **Your strength**
  Focus, perseverance and the ability to support and enjoy the success of my peers.

I acknowledge help from my daughter Dr Piyu Sharma BDS, MPH(LSHTM)in asking me to write elaborate replies and language editing.

Thank you for your time sir!

DR. KUMARI MONALISA
PG - 3
Maulana Azad Medical college,
New Delhi

WITH THE GOLDEN CAVES OF DERMATOLOGY

Dr. Sanjeev Handa

Professor and Head,
Department of Dermatology,
Post Graduate Institute of Medical Education & Research, Chandigarh.

He is Professor and Head of Dermatology, Venereology & Leprology Department at PGIMER, Chandigarh. He has also accomplished fellowship of the American Academy of Dermatology. He has also marked his great work in Paediatric dermatology, Contact Dermatitis, Psoriasis & Pigmentary disorders.

KD : Sir, please share some of your experience in residency and based on the current scenario of Dermatology, how has it changed from your time?

Dr Handa : An experience in residency relates to the submission of my thesis wherein one of my guides made me realize that I had not done my thesis analysis the way it should be. I had very few days left for submission. It was a tense period, sitting with the statistician trying to meet the timeline but also a learning exercise that stood me in good stead all these years. It helped me design all my subsequent studies and projects carefully.

The times are much more resident-friendly now with easy access to information on the internet and ready to use statistical packages which take much less time and effort so completing a thesis should be easy.

KD : How it feels, being the head of India's one of the most pioneer institute? How was your journey through these years?

Dr Handa : I feel blessed and also humbled by the fact that I head the Department of Dermatology, Venereology and Leprology at PGIMER, Chandigarh, which is also my alma mater. I am grateful to God Almighty for the position that I am in today. I owe it to my family, friends and teachers without whose blessings I would not be where I am. A lot of people, including my faculty colleagues and residents, both senior and junior, have contributed to my success in their own way and I am thankful to all of them. The journey has been tough but exhilarating and I would not change it for anything.

KD : Sir what are the courses and fellowships offered at the Dermatology department of your institute?

Dr Handa : We have recently started four observorships in our Department of four weeks duration each for young faculty and senior residents who need experience in the fields of contact dermatitis, paediatric dermatology, general dermatology and dermatosurgery. We also are a center for CODFI Fellowship.

KD : Sir, do you think it matters which institute one graduates from in the long run?

Dr Handa : While brand name and institutional weight do matter, it is the personal effort and dedication put in by a resident which makes one a good clinician.

KD : Sir what are the requirements for recent graduates who would want to join your esteemed institute as faculty members?

A satisfactorily completed senior residency of three years with some good publications is the eligibility criteria. The posts are advertised and vacancies filled through an interview process.

KD : What would be your advice to the residents in their three years of residency? How to excel in academics?

Dr Handa : Do not waste your time in the first year of residency. Consistency is important from the very beginning. Dermatology is a vast subject with very little exposure during MBBS. Residents need to finish at least one standard textbook for each of the three sub-areas of Dermatology, Venereology and Leprology. This translates into reading, analyzing and assimilating six volumes of standard dermatology texts. This requires a lot of hard work and needs to be topped with recent advances from national and international journals to excel.

KD : Being an author of multiple research papers, what would be your advice to the beginners on how to build up interest in research work and write a "clinical paper"?

Dr Handa : Dermatology being a 'visual' specialty, residents need good observational skills and should begin with writing interesting case reports. They should focus sincerely on their thesis publication and then progress onto writing clinical papers. Being brief and having the ability to convey your message is an essential skill for writing papers.

KD : What is better for dermatology residents, private practice or government jobs? Do you any time feel dermatology has reached a point of saturation?

Dr Handa : This is a matter of personal choice; both have their pros and cons. No, India needs many more dermatologists.

KD : How can a resident acquire more from a conference?

Dr Handa : Attend a conference not for the certificate that it gets you but for the academic content and program. My advice would be identify areas of interest, listen to the speakers, clear your doubts. The motto should be study hard, and then party hard.

KD : Sir you might have presented so many presentations. How to become a good presenter?

Dr Handa : Being well-informed about the subject is the first pre-requisite for becoming a good presenter. Be brief and to the point since attention spans are limited. Always plan your talks to give one or two pithy carry-home messages.

KD : How important is it to be updated? Any source for ready reckoners? Which all books do you refer to on a daily basis?

Dr Handa : It is very important to be updated on recent advances in the field. Internet makes it easy to access information from a host of sources.

Rapid Fire

- **Books or e-books?**
  Books – mind has a photographic memory
- **Cosmetology or Clinical Dermatology?**
  Clinical dermatology as the bread and cosmetology as the butter
- **Histopathology or Dermoscopy?**
  Histopathology
- **Rook's/ Bolognia/ Fitzpatrick's/ Lever's/ IADVL (Which book you prefer for residents, in order)**
  Does not matter as long as residents read and try to assimilate the information given
- **Favorite Movie?**
  Avengers
- **Hobby?**
  Travelling; watching National Geographic and Discovery channels
- **Your mentor?**
  My father
- **To marry or not to marry during residency?**
  It depends on how well residents can manage their studies and family life
- **Your strength?**
  My family

Thank you for your time sir!

DR. KINNOR DAS
PG-3,
Silchar Medical College & Hospital.
Sichar, Assam

WITH THE GOLDEN CAVES OF DERMATOLOGY

Dr. Sathish Pai Ballambat

Professor and Head,
Department of Dermatology,
Kasturba Medical College, Manipal.

Dr Sathish Pai Ballambat is currently the Head of the Department of Dermatology, Venereology and Leprosy at Kasturba Medical College, Manipal. He completed his residency from the same institute and has been a faculty at Manipal since 1993. He teaches both undergraduates and postgraduates and his areas of interest include photodermatology and vitiligo surgeries.

FF : Sir, please share some of your experience in residency and based on the current scenario of Dermatology, how has it changed from your time?

Dr Pai : I appeared for the Karnataka PG entrance exam in 1987. I secured a diploma seat in Dermatology at KMC, Mangalore. After Diploma in 1989, I joined for MD at KMC, Manipal. So, I had four years of training as a resident. During my residency we used have regular discussions on various topics, case presentations etc with co- residents after the hospital hours. Sharing knowledge including the notes was the key during these discussions. These discussions were very useful in remembering the topic and also helped us in doing well in examination.

I was very fortunate to work under great teachers and clinicians like Dr J N Shetty, Dr Ganesh S Pai, Dr Jerome Pinto at KMC, Mangalore and Dr C R Srinivas, Dr Balachandran and Dr S D Shenoi at KMC, Manipal. At Manipal, I had the opportunity to get trained in phototherapy, contact dermatitis and dermatosurgery apart from clinical dermatology. In our time choice of dermatology was down the ladder, but now it is one of the most sought out branches for post-graduation. Dermatology has developed into many subspecialties, which is good for the branch as graduates can hone their skills and become expert in these subspecialties.

The major developments in dermatology during the past few decades are in the field of dermatosurgery, cosmetology, lasers, dermatoscopy, and advances in nail, hair and teledermatology. It is good that MCI has made it compulsory to have lasers in all Medical Colleges.

FF : How it feels, being the head of India's one of the most pioneer institute? How was your journey through these years?

Dr Pai : It feels great to head the department of Dermatology at Kasturba Medical College, Manipal, MAHE. My journey started in 1993 as Assistant Professor and then gradually got promoted and in 2014 became the head of the department. During my tenure at Manipal, I was awarded the young dermatologist award by IADVL in 1998 to attend AAD congress at Orlando, USA. I had the opportunity to work as a Commonwealth

fellow at Ninewell's Hospital and Medical School, Dundee, Scotland in the field of photodermatology under the guidance of Dr James Ferguson in 2000. I also had the opportunity to work and head the department of Dermatology at Sikkim Manipal Institute of Medical Sciences, Sikkim from 2005 to 2007.

FF : Sir what are the courses and fellowships offered at the dermatology department of your institute?

Dr Pai : Courses offered are MD and Diploma. We offer IADVL observership in the field of Photodermatology and Immunofluorescence. Our University is also offering short term certificate course in Immunofluorescence. We have a center for sexual medicine and will be shortly starting a certificate course in this branch. We run psychodermatology and sexual dysfunction clinic every week in our OPD. The department also offers clinical observership for residents or graduates as per the University norms.

FF : Sir, do you think it matters which institute one graduates from in the long run?

Dr Pai : Difficult question to answer. Any Institute which offers good clinical exposure in the field of dermatology, venereology and leprosy; inculcates clinical, laboratory, cosmetology, laser and surgical skills, enhances communication skills, attitude, behaviour and EQ of the residents should produce competent graduates.

FF : Sir what are the requirements for recent graduates who would want to join your esteemed institute as faculty members?

Dr Pai : Any graduate can join as senior residents provided there is a vacancy. A graduate from a reputed Institute, publications during residency, conference presentations and a good CV will always carry more weightage during interview for the above post.

FF : What would be your advice to the residents in their three years of residency? How to excel in academics?

Dr Pai : The best way to learn dermatology is to read about the cases you have seen in that particular day. Learn and observe when the teachers are examining, counseling and performing procedures on the patients. Try to make your own notes from different text books and review articles for important topics.

It is always better to discuss, debate a topic, present cases so that you will be able to remember, which will help youduring the examination and also when you practice later. Always be honest and if you do not know the answer simply say "I don't know". Remember that the only thing worse than an overconfident resident is a dishonest one.

There are four important aspects when you are taking care of patients. They are diagnosis, counselling, treatment and explaining the prescription. A proper diagnosis needs good history and examination. The next step is to counsel the patient about the disease and the treatment options. It is very important to explain the prescription and see that the patient has understood all that you have said. If one component is not done well patient may not respond to your treatment.

FF : What would be your advice to the beginners on how to build up interest in research work and write a "clinical paper"?

Dr Pai : It is important to be aware of the scope of your research project including its duration. Attend research methodology workshop either conducted by the Institute or by our Association. Choose an area of interest to you. Apart from your thesis work you can also conduct other research work based on your area of interest or you may get new ideas while conducting your thesis project. A dermatology trainee should publish to prosper and also as an MCI requirement. A case report could be a good beginning. Your thesis work should be published as an original work preferable in a good impact factor journal. To get published in high impact journals the research work should be a high quality randomized trial. Most journal will not accept article immediately. It is usually sent for corrections. Please see that all communications with the journal editor is professional and courteous.

FF : What is better for dermatology residents, private practice or government jobs?

Dr Pai : I have always been in a Medical College after my residency. So I would say teaching profession. It depends on what the resident wants to pursue. If it is teaching it is better to join a Medical College. If he wants to be on his own then private practice. Before putting up private practice it may be prudent to work under a well-established dermatology center to gain extra skills and also to understand the logistics of private practice.

FF : How can a resident acquire more from a conference?

Dr Pai : Try to make notes, write down key messages, clarify with the speaker if you have any queries and give a short presentation of what you have learnt from the conference. Take part and attend quizzes, debates and symposium. The best way to maximize your experience is to take part as a presenter, a session facilitator or committee volunteer.

FF : Sir, how to become a good presenter?

Dr Pai : I always remember the advice of Dr C R Srinivas "think that your audience are ignorant of the subject you are going to talk" keep it simple and convey the message.

Some pearls

- Research the topic of your presentation
- Organize your presentation
- Minimal words in the slides. Use more of diagrams and flow chart
- Use good, high quality images.
- Stick to the time
- Practice for the time allotted. This is important or else you may not be able cover important aspects of your presentation
- Eye to eye contact with the audience and if possible interaction
- Speak clearly

11. How important is it to be updated? Any source for ready reckoners? Which all books do you refer to on a daily basis?

Updating the knowledge is essential as there is continuous development to pathogenesis, investigations and newer treatment modalities. UpToDate is good source. The books that I refer on daily basis are Bolognia, treatment of skin disease - comprehensive therapeutic strategies by Mark Lebwohl and Andrews.

RAPID FIRE

- **Books or e books**
  - Books
- **Cosmetology or clinical dermatology**
  - Clinical dermatology
- **Histopathology or Dermoscopy**
  - Histopathology
- **Rooks /Bolognia/Fitzpatrick/Levers/IADVL (Order)**
  - Rooks, Levers, Bolognia, Fitzpatrick, IADVL
- **Favorite Movie**
  - Sholay
- **Hobby**
  - Cycling, Trekking
- **Your mentor**
  - Dr C R Srinivas
- **To marry or not to marry during residency?**
  - Marry (I got married during my MD)
- **Your strength**
  - Hard work, honesty, punctuality, kind hearted

Thank you for your time sir!

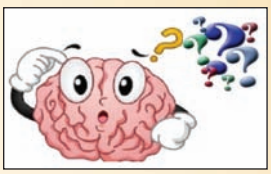
DR. FARHAT FATIMA
PG-3,
Medical College, Kolkata,
West Bengal.

Derma notes-2

Light Microscopy - Sunshine to Dermatology Residents

Being enthusiastic Dermotology residents, in a hope of diagnosing complex dermatological conditions we sit in our OPD along with our senior faculties; then a 3 year old female child with fever and vesicles walks in, with a sad face we enter our side laboratory since our faculty asks us to do a Tzanck smear. As residents we were also told to work with hair specimens for microscopy, vagial discharge, skin scrapings for potassium hydroxide (KOH) mount, slit skin smear for Ziehl Neelson staining and other staining methods.

Thoughts wandering in our brain

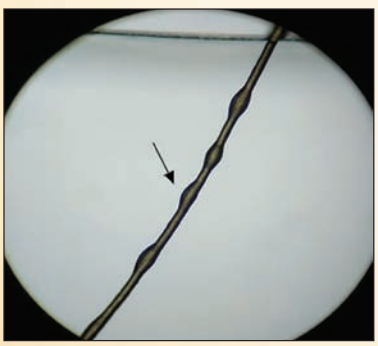


- Why should I do these laboratory works?
- OMG, I am missing the case discussion of Darrier's disease happening in OPD as i am stuck with this Tzanck smear.

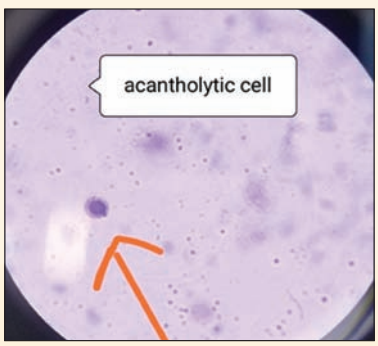
But when I focus an eyecatching multinucleated giant cells-Hurray!!! I have concluded the case as varicella Thus we understood the importance of side laboratory light microscopy in Dermatology.

So, here goes the Saga of our Light Microscopy

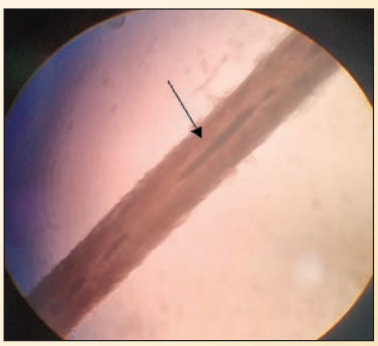
1. Monilethrix in hair microscopy



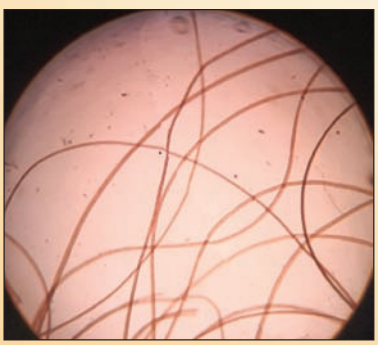
2. Acantholytic cell in a case of Pemphigus vulgaris



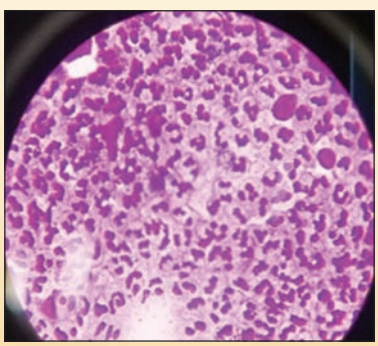
3. Irregular distributed clumps of melaninin Griscelli's syndrome



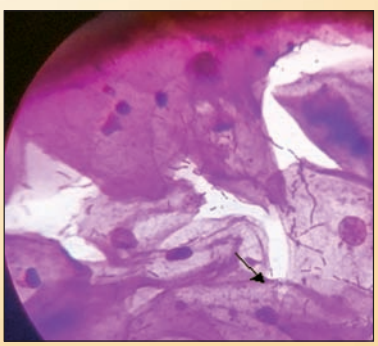
4. Pili Torti in Ectodermal dysplasia



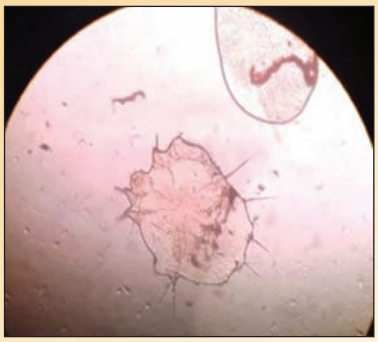
5. Gonococci in Gram's stain



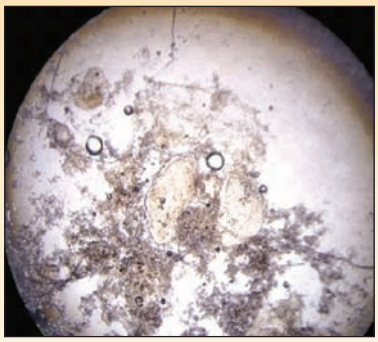
6. Lactobacillus in Gram'sstain



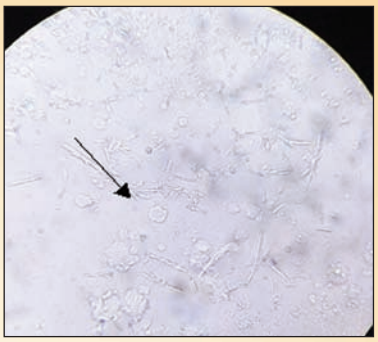
7. Scabies mite in KOH mount



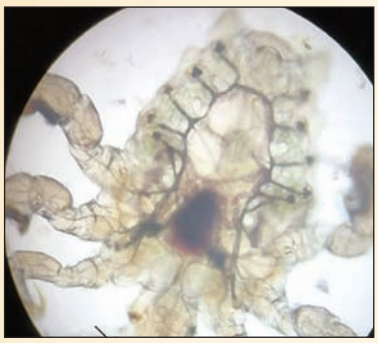
8. Scybala in KOH mount



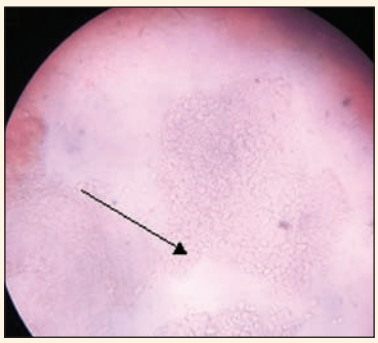
9. Fungal filaments in KOH



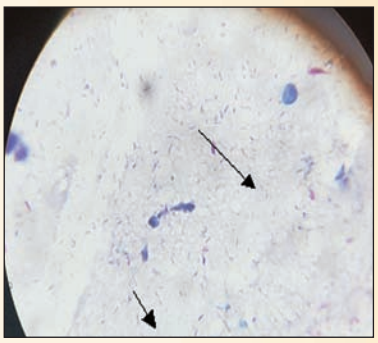
10. Pubic lice in KOH mount



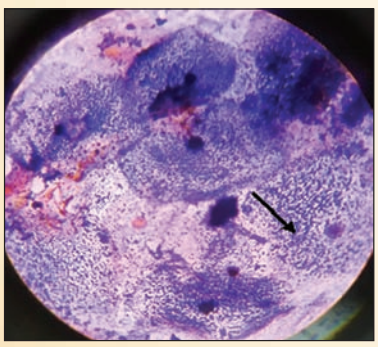
11. Crumpled tissue paper appearance in KOH mount-Molluscum contagiosum.



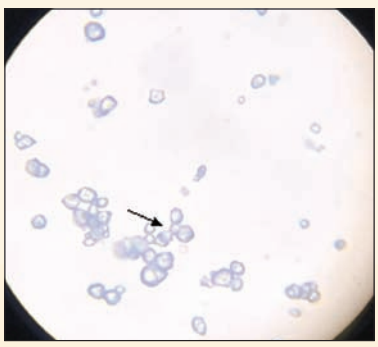
12. Acid fast bacilli in Slit Skin Smear of Hansen's disease



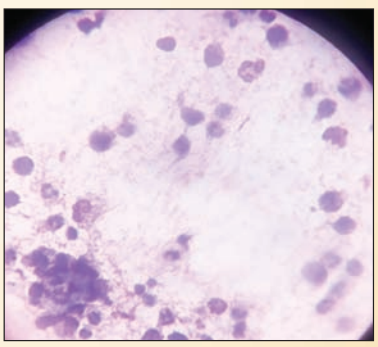
13. Clue cells in Bacterial Vaginosis



14. Molluscum bodies in KOHmount



15. Multinucleated Giant cells in a case of varicella



Now as residents we have answered ourselves, that the light microscopy is one of the important tool in dermatology. Moreover, it helps our confusing residents brain, to confirm the diagnosis

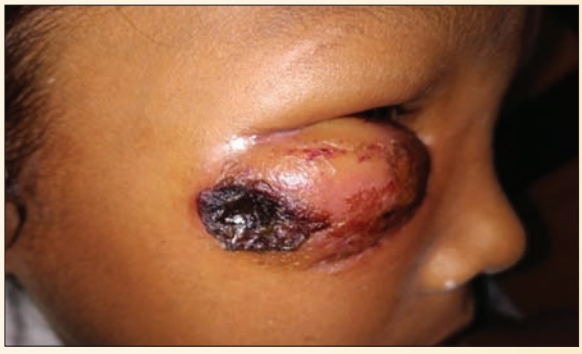
DR. KINNERA BOINA
PG-3
Rangaraya Medical College
Kakinada, Andhra pradesh

DR. SURUTHI PURUSHOTHAMAN
PG-2
Rangaraya Medical College,
Kakinada, Andhra pradesh

DERMA QUIZ!

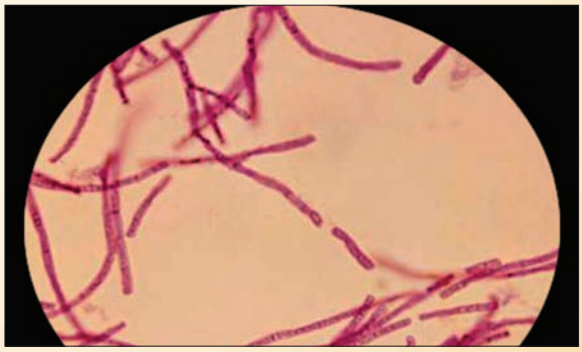
THE FIFTH AND SIXTH PLAGUES OF EGYPT

A 9-year-old female child came to OPD with complaints of painless swelling with mild itching for the first two days, over the right lower eyelid which increased in size gradually, followed by formation of ulcer in 5 days. Initially single vesicle was present which ruptured by itself with serous discharge, which later formed as an ulcer. The ulcer was associated with a dark colored thick crust and yellowish superficial crusting surrounding the ulcer. Immunizations are on schedule and up to date. No history of fever. No history of any bite/sting. History of travel to their native village along with the family members present, but none of the siblings or family members have similar lesions. Swelling is firm to hard to feel and no lymphadenopathy noted. No positive systemic findings. All the routine hematological investigations were normal. Discharge from the ulcer edge is sent to microbiology for Gram staining.



1. Which of the following is the causative organism/ cause for the clinical scenario?

A. Corynebacterium diphtheriae
B. Brown recluse spider
C. Bacillus anthracis
D. Erysipelothrix rhusiopathiae



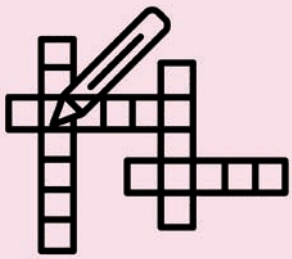
2. Which of the following best describes the cause of the above clinical features?

A. Inactivates Elongation Factor 2
B. Mimics adenylate cyclase enzyme and increases cAMP
C. Overactivates adenylate cyclase enzyme by disabling G(i)
D. Overactivates adenylate cyclase enzyme by activating G(s)

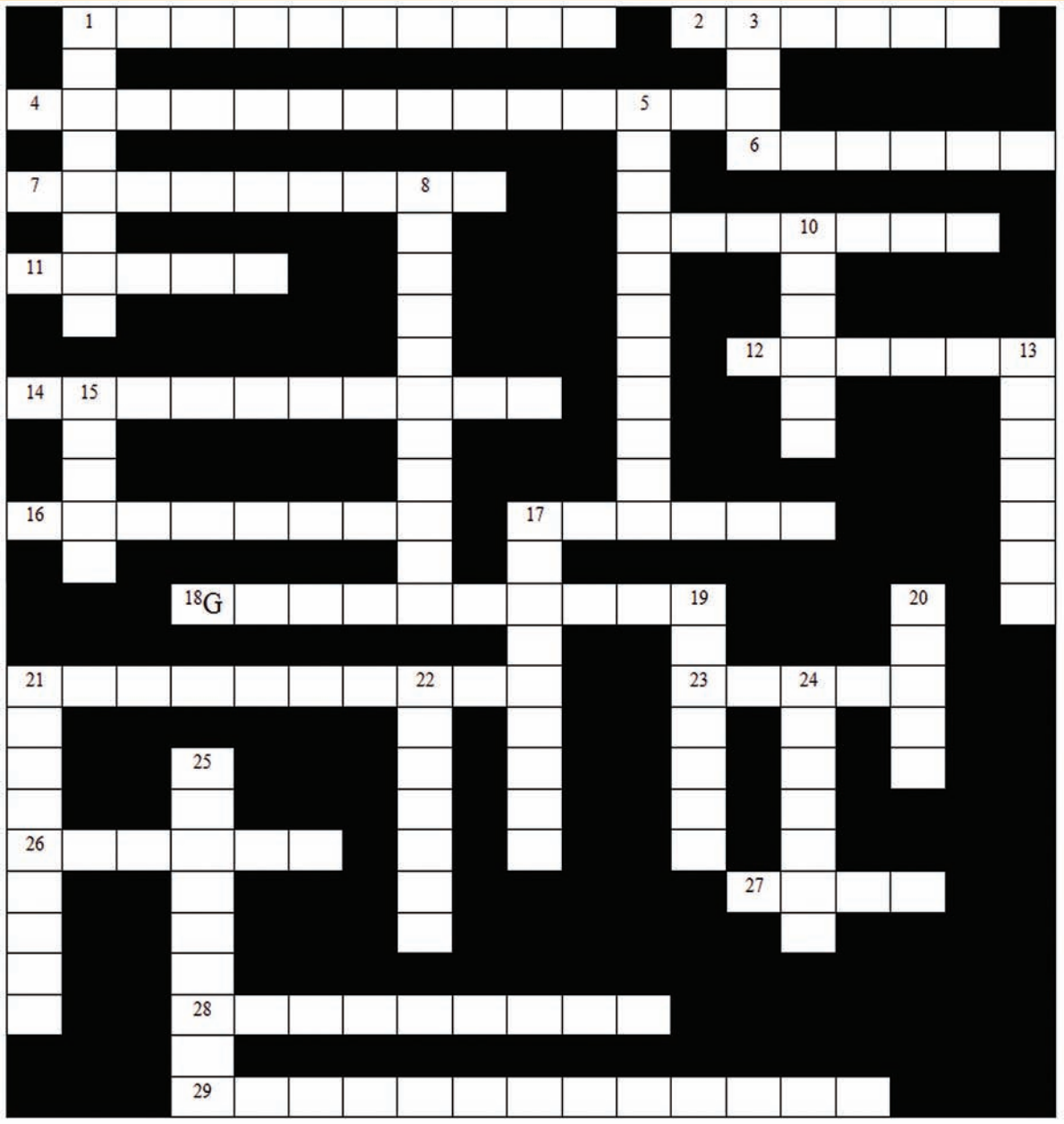
3. What is the best treatment for the above clinical scenario?

A. Ampicillin
B. Ciprofloxacin
C. Vancomycin
D. Penicillin

DR. S. SUDHEER KUMAR
PG-2,
S V Medical College,
Tirupati, Andhra pradesh



CROSSWORD



CLUES : ACROSS :

1. Typical histopathological feature of Kaposi Sarcoma (10)
2. Criteria used for the diagnosis of Bacterial Vaginosis (6)
4. Another name for Toasted skin syndrome (8,2,4)
6. ___ sign: Angulated parakeratosis seen in Pityriasis rosea on histopathology (6)
7. ___ wounds: Gaping wounds over bony prominences following minor trauma, in Ehler Danlos syndrome (9)
9. Auspitz sign, typical for Psoriasis, is also seen in this genodermatosis: ___ disease (7)
11. ___ dermatitis: Dermatitis in persons exposed to Toxicodendron species (5)
12. ___ sign: Term used to describe Diabetic cheiroarthropathy (6)
14. ___ sign: Linear aggregation of neoplastic lymphocytes along dermoepidermal junction, seen in Mycosis fungoides (3, 7)
16. ___ phenomenon: Used to describe an eczematous reaction around a congenital melanocytic nevus (8)
17. ___ bodies: Spores seen on histopathology in Chromoblastomycosis (6)
18. ___ disease: Another name for Sweet's syndrome (4, 6)
21. ___ disease: Apocrine miliaria (3, 7)
23. ___ bodies: Characteristic electron dense bodies seen in Fabry's disease (5)
26. ___ sign: Ragged cuticle seen in Dermatomyositis (6)
27. ___'s sign: Localisation of tenderness of glomus tumor with pinhead (4)
28. ___ sign: Indicates increased length of upper limb in Marfan syndrome (9)
29. ___ disease: Disseminated variant of pagetoid reticulosis form of Cutaneous T cell lymphoma (6,7)

DOWN :

1. ___ bodies: Remnants of keratinocyte nuclei seen in senile nails (8)
3. ___ lines: Transverse lines on nails in arsenicosis (4)
5. Father of laser (6,5)
8. This JAK inhibitor has been recently approved for treatment of Psoriatic arthritis (11)
10. ____'s sign: Eyelid sign in systemic sclerosis (6)
13. ___'s sign: Callosities on knuckles in bulimia patients (7)
15. ____'s sign: Scleral pigmentation in Alkaptonuria (5)
17. ___ alopecia: Most common alopecia seen in syphilis (9)
19. ___'s sign: Follicular hyperkeratosis on face in Multiple myeloma (7)
20. ___ sign: Confluent violaceous macular erythema on posterior neck and shoulders in Dermatomyositis (5)
21. ___ appearance: Term used to describe vesicles in cutaneous lymphangioma circumscriptum (9)
22. Y in Nd: YAG laser stands for? (7)
24. ___ jaw: One of the stigmata of congenital syphilis (7)
25. ___ sign: Sparing of occipital area in Trichotillomania (5,4)

DR. PALLAVI SEKARAN
PG-3,
Gauhati Medical College & Hospital,
Assam

FILL IN THE BLANK.

A. Give the other name of following condition :

1. Kyrle disease_____
2. Dissecting cellulitis of scalp_____
3. Nevus of ota_____
4. Chronic folliculitis of leg_____
5. Candidal infection of web space_____

B. Name the origin of following word

from the group below : [stone, to attack(impetere), peak, crab's claw, fish like, out of place, petty thief, foxes (mange), to boil or flow out, wild fire]

1. Impetigo _____
2. Alopecia _____
3. Furuncle _____
4. Piedra _____
5. Eczema _____
6. Atopy _____
7. Fogo selvagem _____
8. Acne _____
9. Ichthyosis _____
10. Keloid _____

DR. RATNAKAR SHUKLA
PG-3,
Dr. D.Y. Patil Medical College,
Nerul, Navi Mumbai, Maharastra

Match the following

1.	Epidermodysplasis verruciformis	a.	Sneddon wilkinson disease
2.	Hidredinitis suppurativa	b.	Letterer siwe disease
3.	Lichen planus	c.	Erdheim chester disease
4.	Dermatitis herpetiformis	d.	Mucha habermann disease
5.	Sub corneal pustular dermatosis	e.	Anderson fabry disease
6.	Uber lipoid granulomatosis	f.	Vincent's angina
7.	Acute disseminated LCH	g.	Lewandowsky lutz syndrome
8.	PLEVA	h.	Verneuil's disease
9.	Acute necrotising ulcerative Gingivitis	j.	Erasmus Wilson disease
		k.	Duhrin Brocq disease
10.	Angiokeratoma corporis diffusum universale	l.	Devergie's disease

CASE REPORTS

PEMPHIGUS PELLAGROSUS : A RARE AND FORGOTTEN ENTITY

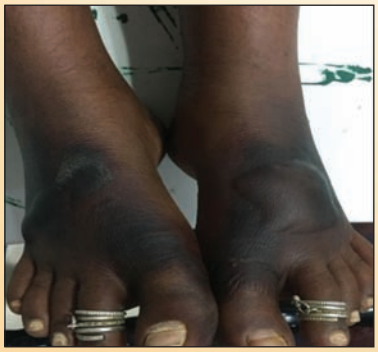
Dr. SAHITYA TADI, Dr. RAKESH DARLA, Guntur medical college, Andhra Pradesh.

INTRODUCTION : Pellagra or niacin (vit B 3) deficiency, a potentially fatal disease is now rare in developed world [1]. It is characterized by dermatitis, diarrhea, dementia and eventually death occurring as a result of niacin or its precursor tryptophan deficiency. The classical triad of dermatitis, diarrhea, dementia is not always present. Full triad of symptoms occur only in 22% of patients [2, 3]. Pellagra cases associated with development of bullae is known as wet pellagra or pemphigus pellagrosus.Pellagra is commonly seen in chronic alcoholics, malabsorption syndrome and drug toxicity. Prolonged therapy with drugs like isoniazid, pyrazinamide, azathioprine, 6-mercaptopurine, sulfonamides, anti-convulsants and anti-depressants result in pellagra like symptoms. Characteristic skin lesions generally precede other symptoms and are pathognomic. They present with symmetric sunburn like eruptions and peeling over exposed areas. Diagnosis is often delayed owing to nonspecific symptoms and low clinical suspicion. Diagnosis is essentially clinical, with a therapeutic trial for confirmation [4]. Treatment includes balanced diet and niacin supplementation.

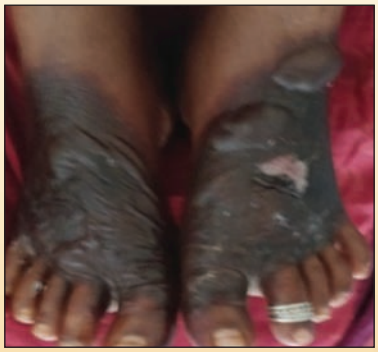
CASE REPORT :

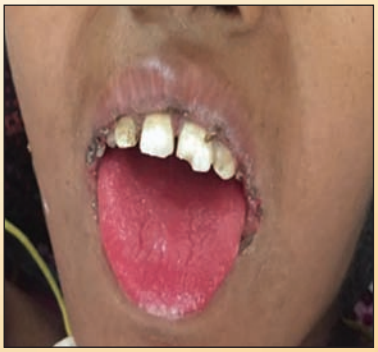
A 25 year old female, known case of pulmonary tuberculosis on Anti-tubercular therapy (ATT) for 2months presented to casualty with symmetrical, sharply defined, hyperpigmented plaques along with bullae on the neck, dorsal surface of the hands, extensor surface of forearms and feet, especially on the sun-exposed areas. Patient has complaints of nausea and erosions involving oral cavity and genital mucosa. There was no history of any neuropsychiatric symptoms. She denied history of any systemic or local application of medication. She was moderately built and nourished with mild pallor and red glossy tongue. Blood and urine investigations are within normal limits. Initially she was diagnosed as drug reaction and was started on steroids, patient did not respond, and her gastric symptoms increased.

Bullae progressed day by day and lesions on neck and forearms showed a burnt-out picture. Based on the characteristic skin lesions overlying sun exposed region, development of diarrhea and isoniazid usage, diagnosis was revised as Wet pellagra.

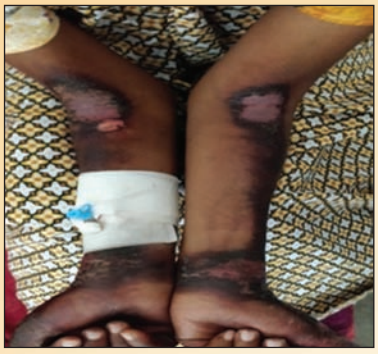


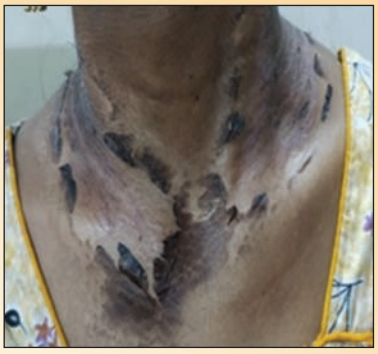
Bullae over dorsum of feet





Beefy, red tongue





Burnt out like picture of hands and neck

DISCUSSION : Pellagra is common in raw-spirit drinkers of rural populations in the Third World whose staple diet is niacin deficient jawar or maize with inadequate animal protein, fruits and vegetables[5]. Secondary deficiency of niacin occurs in malabsorption, carcinoid syndrome, cirrhosis of liver and Hartnup disease. Prolonged therapy with pyrazinamide, isoniazid, 6-mercaptopurine and 5-flurouracil may also result in pellagra like syndromes. Pyrazinamide and isonicotinic acid hydrazide (INH) are structural analogues of niacin and can depress endogenous niacin production by feedback inhibition or substrate competition. INH impairs the functioning of pyridoxine, a cofactor in tryptophan-niacin pathway and inhibits the niacin synthesis leading to pellagra[5]. Nicotinamide is the preferred supplement, as niacin causes flushing and headaches[6,7].

The characteristically described three Ds of pellagra, diarrhea, dementia, and dermatitis are not present in all cases. Skin lesions are classic, characterized by photosensitive eruption[8], symmetrically distributed on dorsum of hands, forearms, and sometimes feet[9].

Anorexia, nausea, and diarrhea are the main gastrointestinal complaints. Cheilitis, stomatitis, red bald tongue, and ulcerations can occur in the oral mucosa. The mucosa of the vaginal and perianal regions can also be affected[10].

Photosensitive skin lesions are due to the deficiency of urocanic acid, which acts as an ultraviolet filter[8,10.]

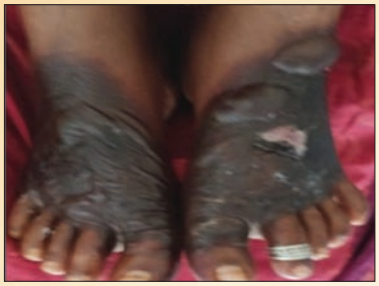
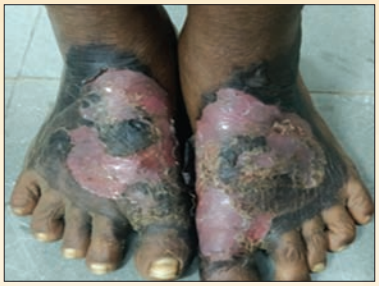
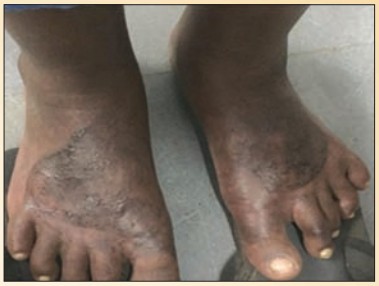
In pellagra, nicotinamide adenine dinucleotide (NAD) and nicotinamide adenine dinucleotide phosphate (NADP) levels are inadequate to maintain cellular energy transfer reactions. Tissues with a requirement of high energy like the brain and those with a high turnover of cells like the gastrointestinal tract and skin are particularly affected[11.]

The recommended daily allowance is 0.66 mg per 1000 Kcal (10–20 mg/day). Since niacin causes unpleasant flushing, itching, burning, or tingling sensations, niacinamide is preferred for therapy and 300–500 mg/day orally in divided doses is recommended. When oral therapy is precluded, 100 mg of niacinamide is injected intramuscularly three times a day. In severe cases with encephalopathy, 1000 mg of niacinamide is recommended orally in addition to 100–200 mg parenterally. The skin erythema, mucosal lesions, and diarrhea respond in a few days. The skin lesions disappear completely in a few weeks. B complex vitamins, pyridoxine, and riboflavin are needed for the neurological manifestations. Proteins and iron should also be given. A balanced diet should be prescribed[12.]

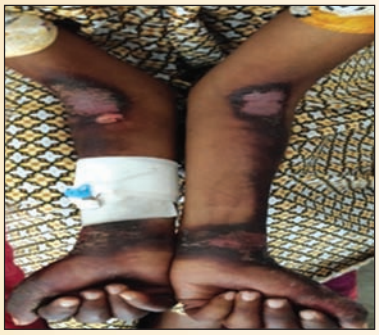
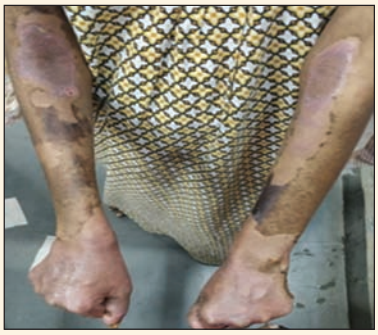
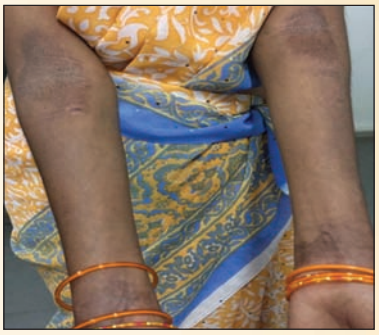
CONCLUSION : Pellagra is seen routinely with characteristic hyper pigmented plaques on sun exposed areas, the development of vesicles and bullae with mucosal erosions is seen only in few cases in this era. If pellagra is diagnosed early and treated appropriately, the prognosis

will be very good as is seen in our patient. This case is probably an isoniazid induced pellagra. Isoniazid is a competitive inhibitor of NAD because of similar structure and it also impairs pyridoxine functioning, which is essential for niacin synthesis from tryptophan.

Before treatment : **After treatment :**

RESIDUAL HYPERPIGMENTATION

REFERENCES :

1. Thornton AM, Drummond CJ. An unexpected case of pellagra. Med J Aust.2014May19;200:546-8.
2. Spivak JL, Jackson DL. An analysis of 18 patients and a review of the literature. Johns Hopkins Med J.1997;140:295-309.
3. Oztürk F, Koca R, Aydin M, Cantürk MT, Akpolat I, Küçüködük S. Pellagra: a sporadic pediatric case with a full triad of symptoms. Cutis.2001Jul;68:31-4.
4. Isaac S. The "gauntlet" of pellagra. Int J Dermatol. 1998Aug;37:599.
5. Das R, Parajuli S, Gupta S. A rash imposition from a lifestyle omission: a case report of pellagra. Ulster Med J.2006 Jan;75:92-3.
6. Hegyi J, Schwartz RA, Hegyi V. Pellagra: dermatitis, dementia, and diarrhoea. Int J Dermatol 2004;43:1-5.
7. Piqué-Duran E, Pérez-Cejudo JA, Cameselle D, et al. Pellagra: a clinical, histopathological, and epidemiological study of 7 cases. Actas Dermosifiliogr 2012;103:51-8.
8. Burnett CT, Lim HW. The photosensitive patient: Could it be pellagra? Br J Dermatol 2011; 164:1178-9. Hariharasubramony A, Chankramath S, Prathyusha D.
9. Hariharasubramony A, Chankramath S, Prathyusha D. A case of alcohol-dependent syndrome and pellagra. Int J NutrPharmacolNeurol Dis 2013; 3:61-3.
10. Wan P, Moat S, Anstey A. Pellagra: A review with emphasis on photosensitivity. Br J Dermatol 2011; 164:1188-200.
11. Creeke PI, Dibari F, Cheung E, van den Briel T, Kyroussis E, Seal AJ. Whole blood NAD and NADP concentrations are not depressed in subjects with clinical pellagra. J Nutr 2007; 137:2013-7.
12. Sacchidanand S, Chetan O, Arun C. IADVL Textbook of Dermatology, 4th Edition. India: Bhalani Publishing House; 2015.

DR. SATHIYA TADI
PG-3,
Guntur Medical College,
Andhra Pradesh

DR. RAKESH DARLA
PG-3,
Guntur Medical College,
Andhra Pradesh

Cerebriform nevus sebaceous : A unique presentation

CASE REPORTS

DR. POOJA ARORA, DR. SINU ROSE MATHACHAN, Dr. Ram Manohar Lohiya Hospital & PGIMER, New Delhi

Abstract : Nevus sebaceous is a congenital epidermal nevus with cerebriform type being a very rare morphological variant of it. Usually it presents as a single plaque on the scalp with overlying alopecia; however, it can also appear on face, neck and chest. We report a case of congenital cerebriform nevus sebaceous in a 25 year old male located on the face with tightly packed invaginations and a smaller size.

Keywords : Nevus sebaceous, Cerebriform.

Introduction : Nevus sebaceous (NS) is an epidermal organoid nevus and the cerebriform type is a very rare variant of it. It has been given the name cerebriform, as the lesion is characterized by sulci or well-marked meandering invaginations macroscopically. Classically, it is present at the time of birth as a single plaque with alopecia over the scalp. The cause for the cerebriform appearance is not known[1]. Mosaic genetic mutations in the Harvey Rat Sarcoma (HRAS) and Kirsten Rat Sarcoma (KRAS) genes are thought to be the underlying cause of this congenital hamartoma[2]. Our patient had a lesion with a clinical appearance that is quite unique from the cases of cerebriform NS hitherto described.

Case Synopsis : A 25-year old male presented with asymptomatic, raised pigmented lesion 4 cm lateral to the left eye of size 5 x 5 cm since birth. Lesion increased proportionately with the body size. There were no associated systemic abnormalities. On cutaneous examination, a single 5 x 5 cm hyperpigmented, soft, well circumscribed, plaque with closely arranged multiple folds and a cerebriform appearance was present lateral to left eye (Figure 1). Routine hematological investigations were normal. Histological examination revealed hyperkeratosis, acanthosis, papillomatosis, epidermal hyperplasia with follicular plugging and large number of mature sebaceous glands surrounding the underdeveloped hair follicles in the upper dermis (Figure 2, 3).

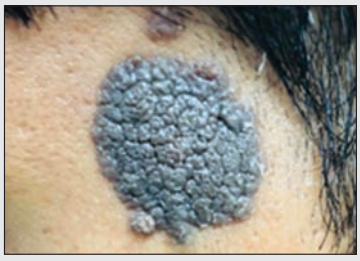


Figure 1. Cerebriform lesion lateral to left eye.

Case Discussion : Nevus sebaceous is an uncommon hamartoma with an incidence of 0.3% in the neonates[1]. Cerebriform NS is one of the rare variants and was first described by Ramesh et al[3]. He reported a large cerebriform plaque over the right parieto-occipital region in a 20-year-old man. Correale et al reported 5 cases of large papillomatous cerebriform NS since birth[4]. Four of them were located over scalp and one case had NS extending from scalp to elbow.

Extensive cerebriform NS involving head, face and trunk has also been described[1]. All the cases reported so far were large exophytic lesions and most of them being confined to the scalp.

Histology of nevus sebaceous varies according to age. Sebaceous glands may be underdeveloped in early years of life. Second stage begins during puberty characterized by mature sebaceous glands. NS becomes more verrucous and nodular in this stage indicating the role of hormones and giving a cerebriform appearance. The final third stage during adulthood presents with appendage tumours of which syringocystadenoma papilliferum is the most common.

The risk of malignancy arising from NS is less than 1% and basal cell carcinoma being the most common. Other malignant tumours may include malignant eccrine poroma, sebaceous or apocrine carcinoma

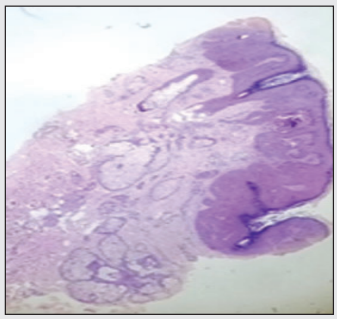


Figure 2. Histopathology showing hyperkeratosis, acanthosis and papillomatous hyperplasia of epidermis with follicular plugging and large number of mature sebaceous glands in the upper dermis (10x).

and rarely squamous cell carcinoma[5]. If nevus sebaceous is associated with central nervous system, oculocardiac or skeletal abnormalities, then it's called as linear nevus sebaceous syndrome, or schimmel penning syndrome[6]. The differential diagnosis for NS are epidermal nevus syndrome, congenital melanocytic nevi, giant seborrheic keratosis and warts which are difficult to differentiate clinically. The histopathological differentials include sebaceous hyperplasia (shows mature sebaceous gland lobules and prominent sebaceous ductal structures), adenoma (sharply demarcated structure made of immature lobules), carcinoma (mitotic structures with undifferentiated growth) and sebaceoma (basaloid cells predominate along with sebaceous cell ducts)[7]. Other conditions showing cerebriform appearance are cutis verticis gyrata, intradermal nevus, proteus syndrome, collagenoma and lipomatous nevus[5]. Indications for treatment depends on the psychological, cosmetic and social impact, as well as the risk for malignancy. Treatment of choice is wide excision of the lesion and should be done at an early age to avoid malignant transformation as well as unsightly scars. Other management options include photodynamic therapy and CO2 laser[7]. Our patient was referred to plastic surgery for wide excision and skin grafting.

Conclusion : This case conveys a unique clinical appearance of cerebriform nevus sebaceous with closely arranged invagination and a smaller size located on the face.

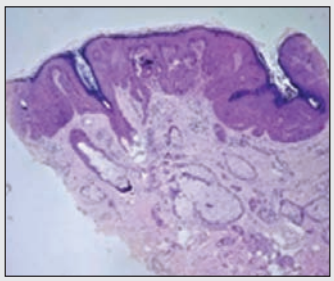


Figure 3. Histopathology showing hyperkeratosis, acanthosis and papillomatous hyperplasia of epidermis with follicular plugging and large number of mature sebaceous glands in the upper dermis (40x).

References :

1. Mahajan R, Dogra S, Kanwar AJ, Saikia UN, Agrawal S. Extensive cerebriform nevus sebaceus: An unusual presentation. Dermatology online journal. 2012;18(5):9.
2. Lee JD, Kim HS. Cerebriform Nevus Sebaceous. New England Journal of Medicine. 2015;373(3):262.
3. Ramesh A, Murugusundaram S, Kumar KV et al. Cerebriform sebaceous nevus. Int J Dermatol 1997; 37:220.
4. Correale D, Ringpfeil F, Rogers M. Large, papillomatous, pedunculated nevus sebaceus: a new phenotype. Pediatric Dermatology 2008; 25:355-358.
5. Cunha Filho RR, Fezer AP, Lorencette NA. Cerebriform sebaceous nevus: a rare presentation. Anais brasileiros de dermatologia. 2015;90(3):160-1.
6. Maheshwari V, Alam K, Prasad S, Sharma R, Khan AH, Sood P. Cerebriform nevus sebaceus: A rare entity. Dermatology online journal. 2006;12(7):21.
7. AQureshi NA, Singhal J, Sharma J. Cerebriform Nevus Sebaceous of Jadassohn. Indian pediatrics. 2013;50:1071

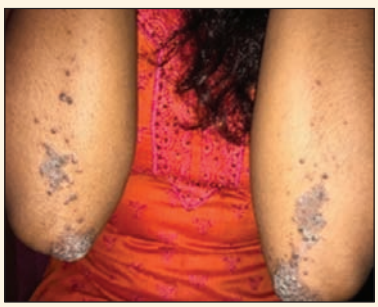
DR. SINU ROSE MATHACHAN
PG-3
Ram Manohar Lohiya Hospital &
PGIMER, New Delhi

SYMMETRICAL ACROKERATODERMA : A CASE REPORT

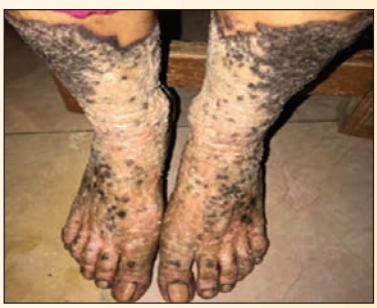
DR. KAAVYA N., DR. G. RAMESH KUMAR, DR P. VENKATA RAMANA, Sri Venkateshwara medical college, Tirupathi, AP

Background : Symmetrical Acrokeratoderma is a variant of Erythrokeratoderma presenting with asymptomatic brown to black hyperkeratotic plaques symmetrically distributed over acral areas but characteristically sparing palms and soles. Lesions typically become white and macerated rapidly after water immersion or sweating[1]. In India very few cases of symmetrical acrokeratoderma have been reported.

Case scenario : A 20-year-old female presented with complaints of thickened skin over both lower limbs, hands, elbows and knees since the age of 13 years. Patient was normal at birth. Her mother had similar complaints. There was no history of consanguinity of parents. On examination, well defined hyperkeratotic, hyperpigmented plaques were foundover lower one third of both lower limbs and maceration was notedover dorsum of both feet on immersion in water. Skin over knuckles of fingers were minimally involved. Palms and soles were normal. Routine investigations were normal. Histopathologic examination revealed hypertrophic stratified squamous epithelium with hyperkeratosis, parakeratosis, pseudo-horn casts and focal acanthosis. Dermis showed proliferating capillaries with perivascular lymphocytic collection. Many pilosebaceous units were noted. Based on the aboveclinocopathologic findings, diagnosis of Symmetrical Acrokeratoderma was made. Patient was started on oral retinoids, topical retinoids and steroids with moderate response.



Acrokeratoderma involving the elbow



Acrokeratoderma involving the lower limbs

Discussion : Symmetrical Acrokeratoderma is a distinct disorder predominantly affecting young age group which is characterized by brown to black hyperkeratotic plaques symmetrically distributed over acral regions sparing palms and soles.In a recent study there is a proposal for a new term, 'pigmented carpotarsal hyperkeratosis' in place of symmetrical acrokeratoderma[2].Most of the cases have been reported in Chinese men. Here, we are describing a female with the characteristic features. It is important to identify cases of symmetrical acrokeratoderma, even though it is a rare entity, but it may be more frequent than thought.

Several hypotheses have been proposed to explain the pathogenesis. A study showed moderate increase of trans-epidermal water loss and reduced skin hydration values in patients with symmetrical

acrokeratoderma[3]. Ultrastructural studies have shown keratin filaments with tight clumps or aggregations in the perinuclear cytoplasm with irregular distribution in all the layers.Intact desmosomes as well as partial splitting of the desmosomes in the stratum spinosum have been reported. Perhaps,the unique changes observed after water immersion are due to abnormalityin epidermal barrier function. In line with the previous report, after immersing in water, we could appreciate loosening of the stratum corneum, but the rest of the epidermis was apparently normal on light microscopy[4].

Traditionally, the diagnosis of Symmetrical acrokeratoderma is based on the following clinicopathologic features:

(1) disorder predominantly affecting young men
(2) brown to black hyperkeratotic patchessymmetrically distributed over theacral areas, particularly on the wrists, ankles, andback of hands and feet, but sparing palms and soles
(3) the lesions become whitish and macerated rapidly afterimmersing in water or after sweating,but recover gradually after drying
(4) subjectivesymptoms are often absent except for mild itch
(5) lesions worsen in summer but alleviate in winter
(6) histopathologic examination showing epidermalhyperkeratosis, acanthosis, and superficial periva scular lymphohistiocytic infiltrate[5].

No specific therapy is available. Temporary improvement is brought about by the usage of systemic and topical retinoids, topical antifungals, steroids and keratolytics[5].

Conclusion : Symmetrical acrokeratoderma is a distinct disorder and should be considered, even though it is a rare condition in India. The unique feature that differentiates symmetrical acrokeratoderma from other acquired/inherited keratoderma is the white maceration seen after exposure to water. These case reports are significant as they spread awareness about rare diseases worldwide and encourage research workers to find the definite pathology and management of such cases.

References

1. Yan H-B, Zhang J, Liang W, Zhang H-Y, Liu J-Y. Progressive symmetric erythrokeratoderma: Report of a Chinese family. Indian J Dermatol Venereol Leprol. 2011;89:597.

2. Chen W, Song Z, Yang C-C, Hao F. Symmetrical acral keratoderma revisited: proposal for a new term, 'pigmented carpotarsal hyperkeratosis.' J Eur Acad Dermatol Venereol. 2019;33(2):277–80.

3. Li CX, Han CL, Zeng K, Zhang XB, Ma ZL. Clinical, demographic and histopathological features of symmetrical acral keratoderma. Br J Dermatol. 2014;170:948–51.

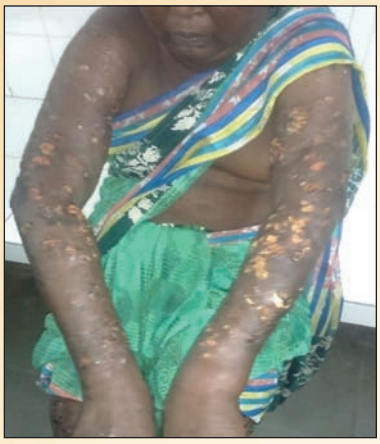
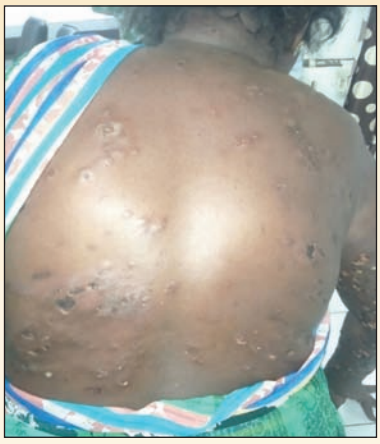
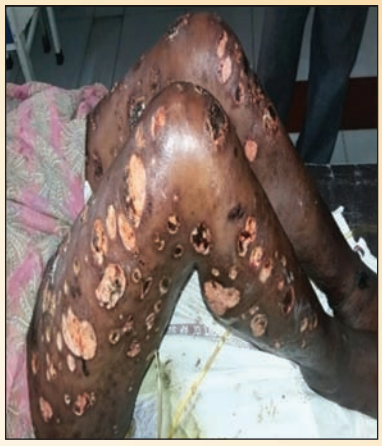
4. Vinay K, Sawatkar GU, Saikia UN, Dogra S. Symmetrical acrokeratoderma: a case series in Indian patients. Orphanet J Rare Dis. 2016;54:78-9

5. Liu Z, Zhou Y, Chen RY, Shi G, Li W, Li SJ, et al. Symmetrical acrokeratoderma: A peculiar entity in China? Clinicopathologic and immunopathologic study of 34 new cases. J Am Acad Dermatol. 2014;70:533–8.

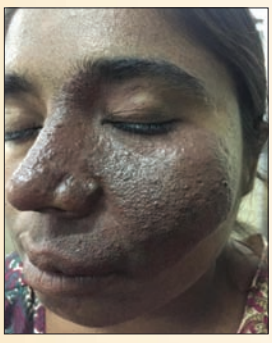
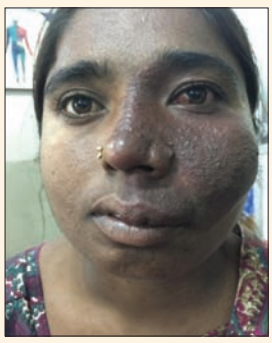
DR. KAAVYA N.
PG-3
Sri Venkateshwara medical college,
Tirupathi, Andhra Pradesh.

Photo Report

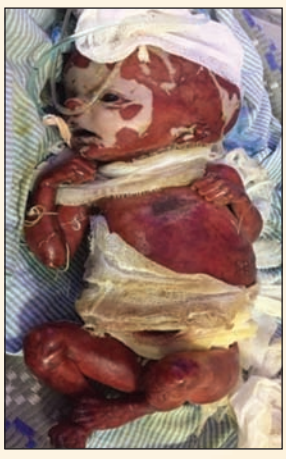
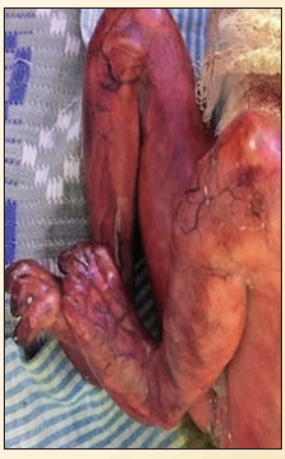
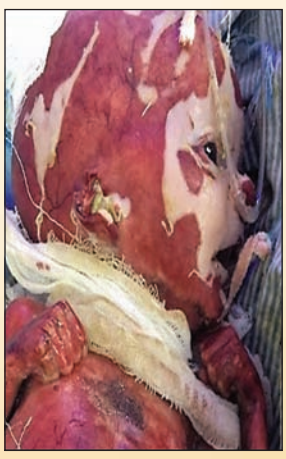
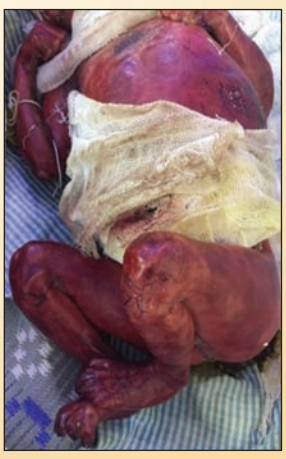
Dr. SATHIYA TADI, DR. RAKESH DARLA, Guntur medical college, Andhra Pradesh.

Erythema Nodosum Leprosum Necroticans : A rare reaction pattern in Leprosy

Hypertrophic naevus flammeus

Systemic aplasia cutis congenita

Dr. SATHIYA TADI
PG-3,
Guntur Medical College,
Andhra Pradesh

DR. RAKESH DARLA
PG-3,
Guntur Medical College,
Andhra Pradesh

Resident's Voice

From a Dream to a Lifelong Vocation

DR. ASHWINI R MAHESH, PG-3, GSL medical college, Rajhamundry, Andhra Pradesh

Someone said 'Don't be afraid to start over again. This time you are not starting from scratch, you are starting from experience.'

This statement holds very good in my case as I went on to do my post-graduation twice from two different institutes, one was Diploma and the other MD. During my internship, I was drawn towards dermatology, the fact that it has a mixture of medicine and surgery pulled me towards it. The first time I wrote NEET, I missed MD dermatology by very few ranks, but I was determined to pursue dermatology, I joined DDVL in one of the most prestigious colleges in the country, Madras Medical college. They say One step may not take you where you want to go, but it takes you away from where you are. I went ahead and pursued my dream subject in my dream college. I was happy, but I wanted more.

Right after my DDVL, I went to Cleveland, USA and worked under Dr Angela kyei and her team. It was an enlightening experience. I also observed Dr Jorge Garcia Zuazaga, from whom I learnt the intricacies of Mohs surgery. Most of the overseas practitioners are friendly, so it's important to talk to them during conferences, and they will be pleased to accommodate you. Cleveland Clinic and similar hospitals offer preceptorship programs, but the only issue is the wait time. One has to make sure that we plan our future well ahead.

Dr. Angela Kyei, MD, MPH, FAAD,
Cosmopolitan dermatology, Cleveland

I enjoyed working with all of them, at the same time, I knew that there was more to learn.I knew that a secondary degree would be a perfect way to fill that void and I attempted the most gruelling exam, NEET again, this time much more equipped and determined to bag a MD dermatology seat.

After NEET, I applied for a US based fellowship in Anti-aging medicine and chose my hands-on centre as Dubai under Dr Maria Angelo khattar where I learnt all possible techniques right from threadlifts to buttlifts and platelet rich plasma therapy to carboxytherapy. It's important to learn all the techniques ethically as well as scientifically, to be able to give a holistic treatment for the patient. It's more important that you know when to say 'NO'.

Meanwhile, I applied for IADVL observership under Dr Subrata Malakar sir who was instrumental in helping me develop interest in

Dermoscopy. IADVL has a great set of observerships, which I feel everyone should definitely apply. There's never a full-stop to learning. When you go to your mentors place of practice and learn, you get the best of what they have to offer. IADVL observerships are based on merit, so it's very important for one to present as many papers and posters as possible during residency and also work on good publications.

During residency, it's important to be a part of a good platform like Resident Connect. Few states have launched Yuvaderma, one can choose to take active participation in them as well. The Chairperson, Advisor and Convenor are always there to bring out the best in you. If not for Dr Preethi mam's constant encouragement, I wouldn't have penned down this article. One can become a Zonal coordinator during residency. Resident connect provides a medium for showcasing ones talent and be recognized nationally. Residream is a newsletter by the residents and for the residents. One can send articles to the newsletter, that could serve as the steppingstone to publications in future.

I worked in a corporate setup for 4 months before I joined my MD course. I have nothing against them, they provide an alternative learning: they teach you life skills. They help you deal with the outside world with a smile. Who does more work, who takes credit, whose work was more valuable? All this matter in a corporate setup. You must fit into a stereotype. You have no freedom to do anything differently, you are subtly put into a mould. Conformity.

I'm currently pursuing my MD course in GSL medical college under an eminent faculty comprising of Dr G Raghurama Rao sir, Dr Prasad Chowdary sir, Dr Venkatramana sir and Dr. K. A Seetharam sir, who also happens to be the Chairman of IADVL Academy. It's important to learn from everyone around you, for everyone has something to offer.I have revered respect for all my teachers, both past and current. In this past one and half year since I joined the course, I have witnessed the dedication and passion that goes into the making of a good dermatologist, while maintaining very ethical standards.

Now that I have a foundation, I enjoy the subject like never before.I have seen with evidence the satisfaction in diagnosis of an internal disease with the skin findings alone. There's a joy attached to finding an underlying systemic amyloidosis, just by looking at the periorbital purpura. They say the face is the mirror of the mind, and in my perspective, skin is the mirror of internal diseases. Every ailment reflects itself in the skin and you just have to be a Sherlock Holmes.

The more cases you see, the more it gets imprinted in your visual memory , thereby helpful in identifying the recurring patterns.

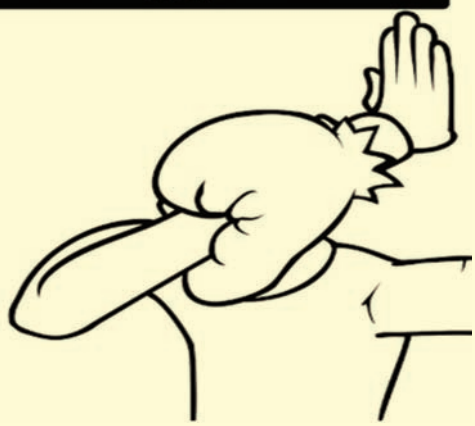
We are fortunate to have a profession that can encapsulate our passions, life purpose, personal essence, and technical skill set all in one sweet package allowing us to exercise our hobbies simultaneously.

At the end, I feel not everyone gets a second chance, if you do get one, take advantage of it, because it's a gift.If you have the opportunity of pursuing a secondary degree, I would say seize it, but it's also necessary that you weigh the importance and pick what you value most. It is very vital that we know who we are and what matters to us so that when we are presented with options, we are clear about the direction and decisions we'll make. 'Thank you' is the best prayer that anyone could say. I say that one a lot. I am extremely grateful to the almighty, my parents, my in-laws, my teachers, my friends, my well-wishers and definitely my husband, who has been very supportive throughout.

When I started counting my blessings, my whole life turned around. Start counting yours...

DR. ASHWINI R MAHESH
PG-3, GSL medical college,
Rajhamundry,
Andhra Pradesh.

On a Sunday EMERGENCY call
ME:what happened??
Patient: pimples
ME: Since when? Patient:3yrs
ME:



When you worked hard to secure a seat in DERMATOLOGY residency

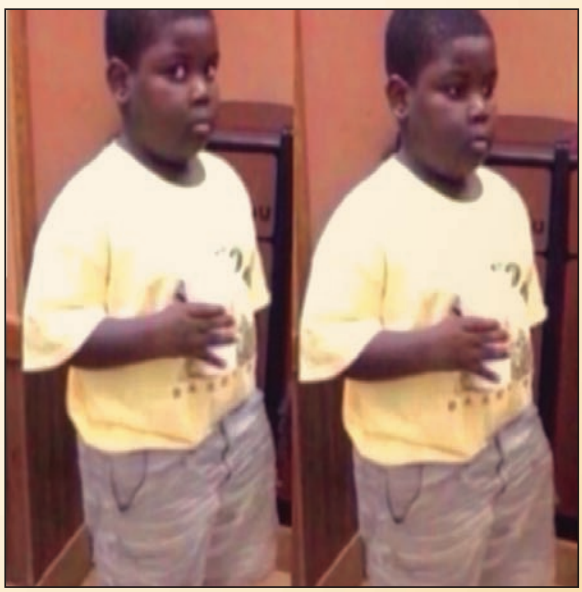
And relatives call you for "Beauty tips"

DR. MANESHA SINGH
PG-1,
Silchar medical college and hospital, Assam.

Eber, Luli and Serta

Achieving Haemostasis in Pyogenic granuloma removal

When consultants cross check ur peripheral nerve examination



DR. ANIRUDH P
PG-2,
Bangalore Medical College and Research Institute, Karnataka.

Derma Quiz : THE FIFTH AND SIXTH PLAGUES OF EGYPT

1. **Answer is C. Bacillus anthracis. The painless black necrotic eschar centrally with erythema and edema around and Jointed bamboo rod appearance on Gram staining are characteristic of Cutaneous Anthrax caused by B. anthracis.**
Cutaneous diphtheria most commonly presents as an ulcer (ecthyma diptheriticum) with a punched-out appearance and grey pseudomembranous eschar, favours acral sites and lesion starts with a pustule (pustular primary lesion is unlikely to be Cutaneous anthrax) followed by crusted dermatitis. Vaccination could not prevent Cutaneous diphtheria. Bite by Brown recluse spider can also have similar picture but will have pain , also here in this case we don't have a history of any bite. Diamond skin disease/ Erysipeloid of Rosenbach/ Pseudoerysipelas is seen in fishermen/poultry workers following a traumatic inoculation of Erysipelothrix rhusiopathiae, presents with a pruritic or painful haemorrhagic vesicle and non-suppurative cellulitis. But the classical finding is the involvement of the finger webs with sparing of the terminal phalanges.

2. **Answer is B. Edema toxin mimics adenylate cyclase enzyme and increases cAMP.**
C. diptheria toxin inactivates Elongation factor 2 and inhibits protein synthesis. Overactivation of adenylate cyclase by disabling G(i) and activating G(s) are characteristic of Pertusis toxin and Cholera toxin respectively.

3. **Answer is B. Ciprofloxacin.**
CDC recommends antibiotic course of at least 60 days rather than 7-10 days. Quinolones (Ciprofloxacin 500mg orally twice daily) are first line agents while Doxycycline can be used as alternative therapy. For post exposure prophylaxis and in cases of bioterrorism, an inactivated cell free filtrate of non-capsulated, attenuated strains of B. anthracis can be administered in adjunct with antimicrobial therapy. Following an initial dose, vaccine is administered at 4 weeks and 6, 12 and 18 months, followed by yearly boosters.

CROSSWORD

SOLUTION :

	1P	R	O	M	O	N	T	O	R	Y		2A	3M	S	E	L	S
	E												E				
4E	R	Y	T	H	E	M	A	A	B	I	5G	N	E				
	T										O		6S	A	L	U	T	E
7F	I	S	H	M	O	U	8T	H			R							
	N						O				9D	A	R	10I	E	R	S	
11M	A	N	G	O			F				O			N				
	X						A				N			G				
							C				G		12P	R	A	Y	E	13R
14T	15O	Y	S	O	L	D	I	E	R		O			A				U
	S						T				U			M				S
	L						I				L							S
16M	E	Y	E	R	S	O	N		17M	E	D	L	A	R				E
	R						I		O									L
			18G	O	M	M	B	U	T	T	O	19N				20S		L
									H			A				H		
21F	O	X	F	O	R	D	22Y	C	E			23Z	E	24B	R	A		
R							T		A			Z		U		W		
O			25F				T		T			A		L		L		
G			R				R		E			R		L				
26S	A	M	I	T	Z		I		N			O		D				
P			A				U						27L	O	V	E		
A			R				M							G				
W			T															
N			28U	M	B	I	L	I	C	A	L							
			C															
			29K	E	T	R	O	N	G	O	O	D	M	A	N			

Fill In the Blanks

A. Give the other name of following condition :

1. Hyperkeratosis follicularis et parafollicularis in cutem penetrans
2. Perifolliculitis capitis abscedens et suffodiens
3. Nevus fusco caeruleus ophthalmo maxillaris
4. Dermatitis cruris pustulosa et atrophicans
5. Erosio interdigitalis blastomycetica

B. Name the origin of following word

1. To attack (impetere)
2. Foxes or mange
3. Petty thief
4. Stone
5. To boil or flow out
6. Out of place
7. Wildfire
8. Peak
9. Fish like
10. Crab's claw

MATCH THE FOLLOWING

1-g, 2-h, 3-l, 4-k, 5-a, 6-c, 7-b, 8-d, 9-f, 10-e

DERMA GLOSSARY

1. Vulgaris - common
2. Lupus - wolf like
3. Lichen - tree moss
4. Planus - flat
5. Herpes - to creep
6. Zoster - belt / knuckle/ Girdle
7. Pityrasis - fine scaling
8. Versicolor - change of colour
9. Eczema - boil out
10. Lentigo - lentil, lens
11. Icthyosis - fish like
12. Furuncle - peety theif
13. Boil - swelling
14. Carbuncle - small pieces of coal
15. Podo - feet
16. Phyllon - leaf
17. Palisade - fence
18. Alba - white
19. Rubra - red
20. Aureus - gold
21. Nigra - black
22. Cryo - ice
23. Grenz - border
24. Xanthoma - yellow tumour
25. Pellagra - pella-skin, agra-rough
26. Rosea - ross red
27. Ochronosis- ochre-yellow
28. Piedra - stone
29. Vitiligo - vitilus calf
30. Comedo - worm like
31. Psoriasis - psoras -itch
32. Guattate – Gutta - Drop
33. Corona - crown
34. Acne - point
35. Ophiasis - serpent
36. Condyloma - round tumour
37. Ainhum - saw
38. Helio - sun
39. Impetigo - to attack
40. Botryomycosis - bunch of grapes
41. Sycosis- small fig
42. Infundibulum - funnel
43. Necrobiosis - state of death and life
44. Sabre - sickle
45. Bonita - Beautiful
46. Agminata - Group of papules
47. Para - beside
48. Multiforme -multiple presentation
49. Actinic - sun
50. Leonine - lion like
51. Panniculus - fat
52. Simplex - simple
53. Myrmecia wart (Anthill wart)-genus of ant
54. Gyratum - emanting/coming out
55. Repens - sudden/unexpected
56. Confetti - small
57. Erythema ab igne-igne - fire
58. Rupioid - red coloured coin like
59. Unguium - nail
60. Mannum - palm
61. Pedia - feet
62. Keloid- claw like
63. Sicca - dry
64. Oleoza - greasy
65. Phemphix - blister
66. Pilaris - hair follicle
67. Squamous - scale like
68. Histio - tissue
69. Nodosum - nodule
70. Café-au-lait - coffee in milk
71. Corymbose-valcano eruptions
72. Limpet-snail like
73. Ostraceous- heaping up of scales
74. Amiantacea- asbestos like
75. Collaratte- small collar
76. Dermatitis- skin is red and itchy

DR. SALECHA AKSHAY JAIN
PG-3,
Dr. Pinnamaneni Siddhartha Institute of Medical sciences,
Andhra Pradesh.

National Resident Connect Committee, IADVL - 2019

Dr. Preethi B Nayak
Convenor

Dr. Umashankar Nagaraju
Chairperson

Dr. Isha Narang
Advisor

Dr. Kinnor Das
North East Zone

Dr. Kumari Monalisa
North Zone

Dr. Ratnakar Shukla
West Zone

Dr. Farhat Fatima
East Zone

Dr. Ashwini R Mahesh
South Zone

We hope you have liked this effort of ours.
mail us your feedback, queries and articles at
iadvlresidream@gmail.com

Regards,
Editorial Team